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ORIGINAL ARTICLES.

AN ETHICAL VIEW OF A MEDICAL QUESTION.

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Herbert Spencer in his "Synthetic Philosophy" says: "In the history of humanity as written, the saddest part concerns the treatment of women; and had we before us the unwritten history, we should find the part still sadder. I say the saddest part, because though there have been many things more conspicuously dreadful—cannibalism, the torturing of prisoners, the sacrificing of victims to ghosts and gods—these have been occasional; whereas the brutal treatment of women has been universal and constant. In looking first at their state of subjection among the semi-civilized, we pass to the uncivilized and observe the lives of hardship borne by nearly all of them—if we think what must have gone on among those still ruder peoples who, for so many thousand years, roamed over the uncultivated earth, we shall infer that the amount of suffering which has been and still is borne by women is utterly beyond imagination. As I have before pointed out, this ill-treatment of women has been an unavoidable concomitant of the chronic struggle for life among tribes, which is still going on in some places, and once was universal.

"The brutality fostered in men by their dealings with enemies unconsciously operated throughout their daily lives. The weakest went to the wall inside the tribe

as well as outside the tribe. The utter absence of sympathy made it inevitable that women should suffer from the egoism of men, without any limit save their ability to bear the entailed hardships. Passing this limit, the ill-treatment by rendering the women incapable of rearing a due number of children, brought about disappearance of the tribe; and we may safely assume that multitudes of tribes disappeared from this cause.

"Only during these later periods of human history in which the destructive passions have not been so constantly excited by the struggle for existence between societies small and large, has the treatment of women slowly become less brutal; and only during the same period has there been growing up among men, a perception that women have certain claims upon them, and a sentiment responsive to this perception."

Mr. Spencer ascribes this change in the conduct of men to women to the fact that character has changed and that customs have been gradually ameliorated, rather than to the fact that they recognize and respect the true ethical basis for this better treatment, and he says that as long as the code of conduct which regulates the general relation of the sexes is thought of as conventional in its origin, it is more apt to be disregarded than when it is seen to

originate in that form of beneficence which seeks to make less unequal the lives of those to whom nature has given unequal advantages.

The pages of fiction tell in glowing words the same story, and *Effie Deans*, *Hetty Sorrell*, *Tess of the d'Urbervilles*, *Trilby* and many other heroines, while they excite our sympathy for their sufferings, rouse in us indignation that penalty should be so unequally distributed and that artificial social distinctions should discriminate so unjustly against those on whom nature has laid the heaviest burdens. Even the medical journals, which are supposed to deal with the purely scientific aspects of life, contain many records and record many pathetic tragedies second to none in fiction to those who are gifted with sufficient imagination to fill out these statistics with the sentiments and feelings which must always go along with them in real life, making us realize that there is yet much to be done and suffered before the true ethical relation between the sexes is reached.

The subject is so difficult, it is so entrenched with prejudices and so many vested interests seem to be enlisted to perpetuate the present injustice, that but for its great importance to the race as well as to individual happiness, we would gladly let it alone, to be cured by the slow process by which other relics of barbarism have gradually disappeared.

It is impossible to tell just how much influence the protests of outraged womanhood against her wrongs may have had in bringing about these changes. It has been said that those who would be free themselves must strike the blow, and the great dramatist tells us that the fault is not in our stars, but in ourselves, that we are underlings. If this is true, silent endurance of wrong sometime ceases to be a virtue, and at last the time comes when it is a manifest duty to tell the truth as we see it, that the cause of justice may have the benefit to be gained from different points of view.

In a recent article in *THE REPORTER*, entitled "The Marriage of Syphilitics," a physician discusses the right of such persons to marry, and he assumes that all about whom there could be any such question, are men. After discoursing on the great danger to which he exposes his innocent wife and unborn children, if his

physician should make a mistake and pronounce him cured when he was not, he says that after he had been thoroughly treated and apparently cured, he should have no hesitation in advising him to marry, as it would be a great hardship to prevent his having the advantages of matrimony. The physical barrier of positive contagious disease being removed, there seems to be no thought given to the lowered vitality and general physical deterioration which he would bring to the marriage union—none to the mental and moral defects with which such diseases are frequently associated, and which often render a happy marriage impossible. There is no suggestion that he should choose a woman similarly afflicted, to whom there would be comparatively little risk, and with whom, should the children all die or be hopelessly idiotic or diseased, there could be no occasion for recriminations, but together they could bemoan their loss and repent of their folly. There is no suggestion that he should plainly state the case to the fair, innocent girl he proposes to invite to share with him the unpleasant harvest which he must reap from the crop of wild oats sown so liberally. Simple justice would seem to dictate such a course, to say nothing of the beneficence which we are told should characterize the relations between husband and wife.

In the same number of the journal, two cases are cited where men contracted gonorrhœa and gave it to their wives, they soon showing the usual symptoms, urethritis, vaginitis with pelvic inflammation, and the usual unconsciousness of the cause of their trouble, with the usual pathetic confidence in the integrity of their husbands, and the narrator asserts that these cases gave him so much "food for reflection" that he brought them to the knowledge of the medical society. There is no record of an operation to remove the poor offending organs which had come to such grief in their legitimate work of perpetuating the race. It will no doubt come later, when these women will make this last offering to the cause, and let us hope it will be placed to their credit in this long and unequal account. In the discussion which followed there was much questioning about just how long, if ever, it was safe for a man to marry after having been apparently cured of this dis-

ease; one gentleman declaring that no man wished to give his wife gonorrhœa, whether she was newly married or otherwise, and especially since so many pelvic diseases which required extensive operative procedure to relieve are due to this cause. He said that the question ought to be discussed and settled, as many authorities maintain that no woman ever marries a man who has had gonorrhœa but suffers in some way from its effects.

These facts turn a powerful light on the causes of disease among women, showing that much which has been usually attributed to her folly, has a different cause. Undoubtedly tight lacing, heavy skirts, imprudence during menstruation and after childbirth, with unwise efforts to prevent conception, may make her less able to contend successfully with these poisonous germs introduced from without, and less able to recover after the frequent operations which are necessary to remove her ovaries and tubes, but they can hardly be

looked on as the real cause of her life-long invalidism. It did not appear, from anything said, what would be considered proper advice to a woman under similar circumstances, but one can safely conjecture that if there were no misgivings about giving her a clean bill of health, there would be great fears entertained lest she might not be morally fit to train children to lives of usefulness and honor, or a suitable companion for a virtuous and honorable man, as there might be some intangible and subtle changes due to her past life which neither drugs nor the most genuine repentance could efface.

The reason for this difference in treatment is hard to justify on any ethical grounds, and though in many ways women are better off to-day than in earlier times, there is yet a long distance to go before we reach that highest form of the sexual relation of which evolutionists prophesy, when each is anxious to make a sacrifice rather than accept one.

ALBUMINURIA AND NEPHRITIS IN CHILDREN.*

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I have designedly separated these two terms, albuminuria and nephritis, as they are not necessarily associated; for albuminuria is present in a good number of morbid conditions without being connected with a renal lesion, and during the course of a nephritis it may disappear or be present in but traces. I shall consider, successively, albuminuria in the new-born, in childhood and in youth.

Examination of the urine should be made in children of every age as well as in adults, though it undoubtedly presents difficulties in nurslings on account of the difficulty of obtaining pure urine. One may, however, succeed in this by tying a sack of goldbeater's skin to the child's penis. Albumin has been found in the urine of the new-born. In tedious labors this has been attributed to asphyxia of the child. In those cases where it is no-

ticed after an easy labor, it has been attributed to the sudden alterations in the circulation which take place at the moment of birth. Thus there follows a period of unbalancing of the vascular equilibrium which gives rise to engorgement of the capillaries of certain regions, and notably to an increase of pressure in the renal arteries. The consequence of this may be in certain cases an immigration of blood-corpuses into the uriniferous tubules and consequent albuminuria, which favors a sort of transitory desquamation of the renal epithelium, especially that of the glomeruli, which is still but little resistant. Therefore one will find in the urinary sediment hyaline casts, epithelial *debris* and urates. The albuminuria of the new-born does not last longer than a week; it presents no active therapeutic indications. One will protect the child from cold by wrapping it in cotton or by placing it into a *couveuse*. Nursing should be conducted with prudence,

*A clinical lecture delivered at Hopital Troussseau, Paris, France. Translated by F. H. Pritchard, M.D., from *La Semaine Medicale*, No. 70, 1894.

the skin might be rubbed, and in case the urine is scanty one might give daily a rectal injection of boiled water.

If albuminuria is regarded as exceptional during the first years of life, it is because the majority of physicians do not look for it except when convulsions and edema invite urinalysis. But if one examine the urine of children who are seemingly well, but living in large numbers together, as in orphan asylums, a proportion of from 6 to 40 out of 100 will present albuminuria. Now, all of these children show some disturbance of health, as impetigo, eczema, digestive troubles, stomatitis, slight forms of tonsillitis or bronchitis. These cases of albuminuria are, therefore, caused by the same factors which give rise to this symptom in larger children and in youths.

In this class as well as in adults, among the most frequent causes of albuminuria besides infectious diseases are gastric disturbances, especially when accompanying a dilation of the stomach with permanent stagnation of food, enteritis and certain pathological states of the liver. In dyspeptic children one may observe transitory albuminuria appearing during the period of digestion and disappearing afterward. These forms are either dependent upon imperfect function of the stomach or intestines or upon a functional insufficiency of the liver. If this latter organ permit the poisons formed in the liver to pass through it, having as it does its function to arrest and to neutralize them in part, and if the glycogenic and biliary functions are inhibited, it may cease for a time to accomplish the physiological transformation of the albuminooids derived from the food into assimilable albumin; there is produced one of those states which has been clinically baptized as "torpor of the liver," to which certain forms of albuminuria without even a transitory renal lesion may be attributed. Again, it is possible that the liver, allowing those poisons to pass which it should physiologically retain (Hegar and H. Roger), and these being eliminated by the kidney, irritate those organs and give rise to an albuminuria which is truly renal. These various forms of albuminuria of gastro-intestinal or hepatic origin are therefore dependent upon auto-intoxication. Hence with reg-

ulation of the diet intestinal antiseptis will successfully manage them.

All forms of poisoning may produce albuminuria; many drugs may do it, as carbolic acid, resorcin, mercury, etc.

In children, as in adults, there may be albuminuria of cardiac origin during the period of asystolia, from venous stagnation in the kidneys.

In growing children, as well as in weak and anemic youths, there is a form of albuminuria which has been termed cyclic. Gull, who was one of the first to study it, attributes it to a nervo-muscular stony; he considered it as almost physiological from the frequency with which it was found, and compared it with the spermatorrhœa of weak and neuropathic youths. Lecorché and Talamon think that it is connected with an alteration, though slight, of the renal parenchyma, a lesion which if cared for ends easily in recovery, but if neglected is prone to run into Bright's disease. It is easily misunderstood or overlooked, though it will not escape you if you follow the advice which I have repeated again and again, not to be satisfied with the examination of a child until you have analyzed its urine.

These cyclic albuminurias give rise to a special clinical picture. The children are languid, pale, fatigued; they easily get out of breath; they complain sometimes of palpitation of the heart; refuse to play; occasionally their appetite decreases or their digestion is disturbed and is accompanied with distention of the stomach and intestines. They suffer from persistent or periodic headaches which assume the form of a migraine, with insomnia and disturbances of vision. These patients, who are frequently regarded as anemic, are not only sufferers from albuminuria, but also often from phosphaturia, which is of importance in treatment.

Certain remedies which are too much lauded as tonics will not relieve these patients. As they are often dyspeptic, those wines which are usually prescribed to strengthen and which are especially rich in alcohol if joined with the so-called "digestive elixirs" (a pitiable abuse of our age) are to be avoided. I advise you in such cases to leave aside cinchona and iron, as well as arsenic, and turn your whole attention to the digestive tract and to the general hygiene, for the disease is usually dependent upon a vicious trans-

formation of the albuminoids in the system. Do not require that these patients eat too frequently of bloody beefsteak, for it is repugnant to them. You will especially prescribe milk diet, then eggs and milk, boiled fish, grilled meats, roast poultry, a good proportion of green vegetables, which are to be well cooked, fruits and *purees*. The nervous system may be stimulated by frictions of the skin with a hair glove or with a mixture of alcohol and turpentine. The child should be taken regularly into the open air, but with avoidance of excessive exercise. One may also employ to a certain extent either sulphurated or salt water baths. The only remedies which I have found useful are strychnine and the phosphates.

Now we must limit ourselves to a study of albuminuria of renal origin. You have seen in the hospital several examples of albuminuria associated with nephritis. In certain cases were purely acute varieties; in others you have been able to follow these into chronic forms. Again, we have been able to diagnose typical chronic varieties. The scarlatina ward especially has furnished us with numerous examples of acute and transitory nephritis. In this disease the invasion of the organism by the toxines may produce from the beginning a suppression of the functions of the kidneys. In other cases later, at the end of eight to fifteen days, secondary nephritis has been observed—a less tempestuous form which was liable to be overlooked if the child leave the hospital too soon; or if it leave off too early milk diet, it may be seized with a nephritis with anasarca, which is the type of acute nephritis of glomerular origin. It may in turn degenerate into a subacute or chronic form and become an epithelial, interstitial or mixed variety of Bright's disease.

You know that one now and then observes nephritis after measles, more frequently in small-pox and exceptionally in chicken-pox, where it has been overlooked until very recently. It is rarely seen during the course of mumps, but very frequently in typhoid fever and sometimes after the grippe.

Diphtheria is one of the diseases most frequently accompanied by nephritis. In the Blache ward there is a little girl of five years whose case I shall present you briefly. After having been sick for several days with a severe attack of diph-

theria she entered, September 28th, the Bretonneau ward, where she was treated by the diphtheritic antitoxine and she was discharged apparently cured. On October 13th she reentered the hospital with a paralysis of the velum palati, a nephritis characterized by ischuria and a great quantity of albumin in the urine, a heart-beat so weak and irregular that we were decidedly alarmed. This little patient is, however, to-day cured of her nephritis, and there only remains a slight paralysis of the palate. With the present state of our knowledge, one might ask if the diphtheria alone is to be accused of having produced a renal alteration which nearly killed our patient. Can the antitoxine act injuriously upon the kidney? "No!" answer MM. Roux and Martin. "Perhaps!" says Cartel. And I do not believe that he is wrong in making this reserve; yet prolonged observation only will settle the question. In the hospital and especially in private practice, in following the children placed under treatment by the serum, it has already been remarked that though the results are remarkable, marvelous even in the immediate effect, it may produce in some children certain side symptoms, as gastric disturbances, vomiting and cutaneous manifestations—not only urticaria, but also papular, circinated, scarlatiniform erythemas, etc.—articular pains, anuria, phosphaturia, urobilinuria and localized and transitory paralyses. One might, therefore, ask if the introduction into the blood of the serum of horses does not exercise an immediate or distant injurious influence upon the organism. I advise you to keep those children under careful surveillance which are treated thus, as well as to keep within the bounds of the necessary dosage, in order not to add by excess of zeal a sero-therapeutic intoxication to the diphtheritic.

Among those varieties of nephritis accompanying infectious diseases, there yet remain to be mentioned those which complicate certain forms of infectious tonsillitis without an exudative membrane in the throat and which are due to streptococci, staphylococci and pneumococci. Professor Bouchard and Dr. Kannenberg have made them well known. Therefore do not forget always to examine the urine of those affected with various forms of tonsillitis, for you will often derive from it important indications. Several years

ago I saw a child with frequently recurring tonsillitis which led to a considerable hypertrophy of the tonsils. After each of these attacks the child would be sick for several days and its urine would contain a notable quantity of albumin. Under the influence of a milk diet it would disappear, but reappear after another attack. Thinking that in one of the tonsils there was a focus of infection and poisoning which gave rise to these phenomena, I called in consultation the surgeon of the family, who, also of my opinion, destroyed the tonsils with the galvano-cautery. Since then the albumin has not reappeared in the patient's urine.

We might complete the list of the forms of acute nephritis by citing those which accompany or follow certain bronchopneumonias; those which are the consequence of ascending infections of the genito-urinary tract and follow a vulvitis, a cystitis, etc.; the toxic varieties, rare, however, in children, as from cantharides, and alcoholic nephritis in children who are forced to drink alcoholic beverages.

I rapidly pass in review as examples of chronic nephritis, those which result from not curing acute varieties; those accompanying paludism, renal lithiasis, a rare form in children; those dependent upon various forms of poisoning, as of intestinal origin, lead and alcohol, and that dependent upon intermittent hydronephrosis. In this latter case the renal pelvis is invaded by microbes and symptoms of pyonephrosis may supervene. Besides, we might cite tuberculous nephritis, amyloid nephritis consecutive to ancient foci of suppuration, which pour their poisons incessantly into the system. This variety is that observed in Pott's disease, in dilatations of the bronchi and in chronic bronchitis. Arterio-sclerosis is rare in children, yet in subjects who have passed through a number of infectious diseases the kidneys may undergo a sclerosis similar to that of the liver.

As to the symptomatology, it does not differ from that of adults. At the beginning of acute nephritis the urine is diminished in quantity. This is a sign which is not to be neglected. Easily noticed in children of a certain age, it is only appreciated with difficulty in nurslings. One must keep account of the number of times that the infant urinates in twenty-four hours. The density is or-

dinarily above the normal; its color may be rose-tinted on account of a slight admixture of blood; hence do not make your diagnosis until after examination under the microscope. We have at present in the hospital a child affected with paroxysmal hematuria, whose urine is frequently of a color varying from that of a currant to that of Malaga wine, without a single red corpuscle being discoverable. Finally, chemical analysis will permit you to recognize both the quantity and quality of the albumin.

One word on the retractility or non-retractility of the albumin, a sign which has been pointed out by Professor Bouchard as of clinical importance. If one heat the urine after having precipitated it by a coagulating reagent, one will observe that sometimes it will break up into a number of flakes which swim in the clear urine and are very distinct from it; again, it may form a single and large clot which appears more or less as a core; at other times, on the contrary, the albumin and the urine remain intimately united and the urine in spite of boiling becomes uniformly opaque. According to Professor Bouchard, retractile albumin is alone associated with lesions of the kidneys, which often are then characterized by the presence in the urine of epithelium and casts only. I have confirmed the exactness of this sign so many times that I believe it to be quite constant.

As to the symptoms of the nervous system, there are headache and disturbances of vision; the digestive system will present vomiting and obstinate diarrhoeas; a dyspnoea which is very pronounced, with hardly a stethoscopic sign noticed in the respiratory tract, save here or there little areas of subcrepitant râles, which Lasègue claims to be characteristic of "albuminuric bronchitis" and which are due to a pulmonary edema. As to the skin, one may observe various erythema, prurigo with little crusts and lesions from scratching, purpura, etc. Never neglect to examine the urine when you have to do with any form of skin disease in a child. At times one may meet with articular pains which may simulate acute rheumatism. Auscultation and percussion will often enable you to perceive a gallop rhythm from hypertrophy of the heart when a chronic nephritis is under consideration. Finally, the serous membranes may be the

seat of effusions—hydrothorax, ascites, hydropericardium. But dropy will be especially noticeable in the subcutaneous cellular tissue or as generalized anasarca, yet frequently as local edema in regions which are easily infiltrated, as the eyelids and scrotum.

The more or less rapid and natural termination of every form of acute or subacute nephritis whenever a sufficient portion of the renal parenchyma is destroyed, is uremia. Hence all treatment has as its object the prevention of this auto-intoxication of the organism which forms the chief danger of all forms of nephritis. The poisons, as Bouchard has demonstrated, are introduced into the economy by several ways: some enter along with the foods, others are derived from gastro-intestinal fermentation, while still others are formed by the cells of the organism itself. All of these poisons must be incessantly eliminated by the natural emunctories or destroyed by the liver or by interstitial oxidation. The kidney is the principal organ of elimination, and whenever it functionates incompletely auto-intoxication commences.

What treatment will enable us to prevent or to combat an already existing auto-intoxication? The first indication would be to choose a food which is as little toxic as possible. Such is milk, which contains but little potash, few organic matters, although enough to replenish the waste of the body, and which, from the lactose and various salts, possesses diuretic properties. If you cannot give milk administer water in abundance, but in small quantities frequently repeated. To favor the expulsion of poisons collected in the digestive tube, one will employ drastic purgatives, such as jalap, scammony or compound tincture of jalap. This should not be too frequently repeated, as it hinders excretion by the kidneys, which throw out more poison than either the intestinal serum or the perspiration. To increase the secretion of urine cold-water injections will be found a precious measure; they produce a spasm of the intestinal vessels which causes the blood pressure in the portal system to increase and thus favorably influences that of the kidneys. I always inquire how the child urinates, and I prescribe cold-water injections whenever I learn that it passes but little water. I have ordered so many as ten or twelve injections a day, and in

cases of anuria even one every hour. In this latter condition it is convenient to inject water under the skin in the form of an artificial serum. If the little patient refuses to drink, one might introduce the water or the milk into the stomach by means of a soft catheter passed through the nostrils. I also employ cold baths, complete or partial cold packs, all of which increase the secretion of urine.

As remedies, different writers advise the salts of potash, squills, digitalis and caffeine. Do not use any of these diuretics, whose irritating action only serves to alter the renal epithelium. The various diuretic beverages owe their properties chiefly to the water and the slight quantity of the various salts of potash—the nitrates, acetates and tartrates—which they contain, but these potash salts all are to a certain degree toxic. As to digitalis, in certain cases it is a precious measure, but whenever the urine is nearly suppressed it is of itself actually dangerous. It then adds its own poisoning to that of the organism, before having succeeded in forcing the barrier, the kidneys. Caffeine does not present the same danger; it may be administered subcutaneously, as it irritates the stomach and provokes vomiting. Therefore, apart from caffeine there is but little advantage to be obtained from diuretics. The sudorifics also are of little value, for themselves eliminating but little poison, they have the disadvantage of decreasing the renal secretion. I have never seen uremic patients receive much benefit from vapor baths. Pilocarpine has been praised by different writers, but there is always the fear of an oversecretion of saliva and the bronchorrhœa which it produces, along with the diaphoresis it produces. When it was employed on Vulpian's recommendation, I have seen patients die before the crisis came on, and then with a considerable increase of the pulmonary râles. Another powerful means of combating uremia is blood-letting, but, unfortunately, this is a difficult operation in little children, as it exposes them to collapse. It has been replaced by the application of wet cups to the lumbar region, which diminish the congestion of the kidney. In Petit's triangle there is a system of emissary veins which establishes a communication between the cutaneous and renal circulation, and, as Renaut, of Lyons, has shown, it is only necessary to re-

move a slight quantity of blood from the kidney to decrease the peritubular and periglomerular edema and to reestablish the secretion thus mechanically compromised. In older patients one may do phlebotomy, often with success; one is rarely obliged to repeat it.

As to other accessory measures, there are inhalations of oxygen and intestinal antisepsis, preferably obtained with alpha or beta naphthol or with the benzoate of bismuth-benzonaphthol. I warn you against the other intestinal antisepsics, as salol or betol, whose elimination might irritate the kidney.

To recapitulate. The various measures which I habitually employ to treat the ischuria, the anuria and uremia in acute nephritis, or in the acute exacerbations of the chronic variety are: Absolute milk diet; plenty of beverages, as water or milk diuretic drinks; intestinal antisepsis; drastic purgatives, as jalap or scammony; frequent rectal injections of cold water, either made with water which has been boiled and then allowed to cool, or with a solution of naphthol (0.20 per cent.); the cold pack; revulsives, as mustard plasters, dry cupping or leeches to the lumbar regions; injections subcutaneously of caffeine or an artificial serum; inhalations of oxygen; finally, in the grave forms blood-letting or wet cupping of the lumbar regions.

There only remains the treatment of the chronic variety after the acute attack has passed over. This is quite difficult and, it must be confessed, quite uncertain. What remedies are to be employed? Tan-nine has been praised, but I have never seen it give any real results. The iodides must be given with caution, yet they are of actual service in chronic nephritis with a predominance of arterio-sclerosis. I only mention the salts of strontium, about which so much noise is being made nowadays, I have seen them diminish the albumin for a short time, after which it would reappear in greater quantities than ever. The phosphates act as tonics, but not upon the kidneys. Therefore, but few or no medicines.

The hygiene should be carefully attended to. You will recommend the parents to keep their child with nephritis from taking cold by covering its skin with flannel; the skin must be kept functioning well by dry-rubbing it with a mixture of alcohol and turpentine. To avoid damp cold, you will advise sending the

child, if it is possible, to the south during the wet and damp months; at all events have it occupy a dry room which looks toward the south. You will also continue the milk diet, which must be interrupted from time to time, as patients grow tired of it, and it is not sufficient to support the body. You will therefore make out a dietary with care to eliminate the harmful foods: meat, and above all that which is but little boiled, as well as those foods which are extracted from it, soup, blood or bouillon; fish, which sometimes contains very poisonous toxines; game, which is still more injurious, as it is often too high. As to vegetables, you will leave out asparagus, gooseberries, tomatoes and cresses. What foods are therefore allowable in chronic nephritis besides milk? Farinaceous and starchy foods; eggs, which are not harmful if well boiled, as their albumen is not the same as that of the blood and they do not increase the albuminuria; green vegetables and certain fruits. As a beverage, always milk, either pure or diluted with a weak mineral water. Alcohol in all forms is forbidden; no wine, no beer. If amelioration set in one may, at a certain time, return to the use of meat, commencing with white meat which is well cooked.

Therefore you have a certain alimentary gamut which you must run through, and which, with prudence, you will interrupt from time to time; putting your patient upon an absolute milk diet and then mitigating it somewhat. In this manner you will greatly lengthen your patient's life by preventing an extension of the renal lesion, for it has been demonstrated that a very small portion of renal parenchyma suffices to sustain existence, with the condition that no acute exacerbation set in from congestion nor a lesion due to a secondary infection, as from a broncho-pneumonia, erysipelas, etc., be added.

During the course of this lecture you have noticed that I rejected the use of drugs, especially when their use was of doubtful value, but the subject is peculiarly appropriate to demonstrate to you that one may carry out excellent and efficacious therapeutic measures without having recourse to drugs. This is more especially and strikingly true in children's diseases than in other branches of medicine, and I shall esteem myself happy if I have succeeded in impressing upon you this which I hold as profound conviction.

COMMUNICATIONS.

THE INDICATIONS AND NATURE OF TREATMENT IN SEVERE AB-
 DOMINAL INJURIES AND INTRA-ABDOMINAL HEMORRHAGES
 UNACCOMPANIED BY EXTERNAL EVIDENCE
 OF VIOLENCE.*

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Every surgeon has undoubtedly at some time in his experience, either in private or hospital practice, met with cases coming under the class covered by the title of this paper. These are cases in which the history and general condition of the patient give the impression that there is a serious lesion within the abdomen, and yet, upon examination, we find total absence or only slight evidences of injury. The tendency, I fear with many, is to treat these patients tentatively, only to be awakened at the autopsy to the fact that a rupture or a tear existed in the abdominal cavity, which, by early radical operation, could have been relieved.

The mortality in these cases is appalling; references to the literature of the subject will amply bear out this statement, which is readily accounted for by the nature of the injuries. Where the lesion is of the liver or spleen, if the patient does not die of shock or hemorrhage, a violent peritonitis supervenes to which he shortly succumbs. If the liver, spleen or kidneys are involved, death from hemorrhage may ensue in a very short time. Should the stomach, intestine or bladder be ruptured and their contents poured into the peritoneal cavity, death from peritonitis is the result. In rupture of the mesentery the danger is from hemorrhage, yet when the opening in the mesentery is small a clot may form sufficiently large to control the bleeding. Should death occur under these circumstances it would be the result of peritonitis caused by the free blood in the peritoneal cavity. I report

a case of this character where recovery followed immediate operation. In ruptured extra-uterine pregnancy death is due either to hemorrhage or peritonitis.

The usual history of these cases, with the exception of extra-uterine pregnancy, is that the patient has received a direct injury to the abdomen, which is found to be unaccompanied by external evidence. These injuries may result from railroad accidents, from being caught between shifting cars, or from blows upon the abdomen received in various ways.

This class of injuries is quite common in military surgery, more so in the past when spherical balls were used and only a low velocity attained. A majority were supposed to be caused by the violence of the wind displaced by the passing ball, but we now know that they were due to the impact of the balls almost entirely spent.

Two cases which illustrate this occurred at the siege of Sebastopol. In neither did the clothing or the abdominal walls show any signs of injury, but in both the liver and spleen were comminuted to a pulp and the intestines extensively lacerated (Mr. Hulke, *Lancet*, December 31, 1892).

As yet we have no reports from surgeons of the armies engaged in the present strife between Japan and China, but it will be of great interest to read the records of such cases. We can expect, I think, a very full and detailed account from the Japanese surgeons. We have all applauded the work of some brilliant individuals of the Japanese profession, and, in fact, we must assign to Japan in medicine the same standing that she has taken in other walks of civilized life, and which she has demonstrated she can hold.

The most prominent symptom is pain, which is accompanied by shock, the degree of which is dependent upon the extent of

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injury and the temperament of the individual.

I might say here that temperament and nationality have a strong bearing in the production of shock. Persons of a highly nervous temperament suffer more from shock than do phlegmatic individuals. For example, Americans are far more liable to suffer a severe degree of shock following injuries or operations than are the Germans.

The pain is peculiar and difficult to describe, but is readily recognized by one who has seen many of these cases and by the patient himself. It is not that of ordinary intra-abdominal affections, but is described by the patient as if something had given way or ruptured, and is usually accompanied by a consciousness of impending death. It is usually accompanied with tenderness, which will be more or less localized, unless the ensuing peritonitis be general. In the early stages of the injury, when shock is most profound, it may not be so pronounced, and if large doses of opium be administered it may be masked throughout the course of the trouble.

When vomiting is present it is usually associated with pain. Rarely does the vomited matter contain blood.

There is often seen a characteristic rigidity of the abdominal walls, which is due to intra-abdominal irritation. I have seen this so marked as to recall to mind the checker-board appearance of the normal abdominal walls as represented in the pictures of the early artists.

In the cases I have observed, consciousness has invariably been retained for varying periods of time. Restlessness is not usual in the early stages except in severe hemorrhage, but later on, when peritonitis develops, it is not an uncommon symptom.

The pulse and temperature vary according to the degree of shock. The former is weak and running, varying from 100 to 160, and the temperature subnormal. If reaction takes place the pulse becomes stronger and less frequent and the temperature reaches the normal line. After reaction peritonitis is invariably the rule, and is accompanied by an accelerated and a high-tension pulse. The temperature under these circumstances is unreliable, as it does not correspond to the degree of inflammation or septic infection. A high

temperature with a slow pulse is less significant than a rapid pulse with a low temperature. In cases of septic peritonitis where autopsy revealed a belly cavity full of foul pus, I have seen the temperature run a normal course throughout the disease.

The part the sympathetic system of nerves, which has its largest distribution in the abdominal cavity, may play in injury to the abdomen is important in considering the differential diagnosis between the simple contusion and contusion accompanied by visceral lesion. In the former the absence of the severe and characteristic pain, of constant and persistent vomiting, of the anxious expression and presentment of impending death, and of any evidence of loss of blood, associated with the occasional presence of suddenly developed meteorism, will usually be sufficient to establish the differential diagnosis. This condition of meteorism is due to paralysis of the muscular coat of the bowel consequent upon the concussion of the plexuses. There are cases, however, where it is very difficult to say definitely whether there be a visceral complication or not. Under these circumstances one can only wait for a comparatively few hours, when, if improvement is not apparent, the operative course is to be pursued. When the solid viscera are the seat of injury hemorrhage will be the main source of anxiety. The pain and the exsanguination give the clue. If the patient should react, which is unusual unless the kidney is the injured organ, we will find, in addition, dullness on percussion in the flank. Rectal or vaginal examination may afford aid in determining the presence of a collection of blood in the pelvis. The solid organs suffer most from external violence on account of their fixity, density and close proximity to the bony structures. The liver is the most often injured, then the uterus, spleen and kidney, in the order named. The stomach is least often injured, there being very few such cases on record. Dr. J. W. Goff (*THE MEDICAL AND SURGICAL REPORTER*, 1892) reports a case of ruptured stomach following a horse-kick of the abdomen, verified by an autopsy. The shock was profound, and there was vomiting with absence of blood. The author states that he believes immediate operation would have saved the patient's life.

In the Glasgow *Medical Journal* for 1894, vol. xli, Andrews reports a case of rupture of the stomach without external evidence of violence, in which all the symptoms of a serious visceral lesion were present with the exception of vomiting. The rupture was upon the anterior wall, was about an inch long and involved all the layers. I cite this case as one of special interest on account of the location of the tear and the absence of vomiting.

The liver is the organ most often affected because of its position beneath the ribs and against the spine, and because it is held firmly in place by strong ligaments and blood-vessels. It is most commonly ruptured on its upper surface, generally in the right lobe, and in a majority of such cases the injury proves fatal. Dr. H. P. Loomis (*Medical Record*, January, 1893) reports a case where the patient was struck by a pole protruding from the back of a wagon, which, when the wagon turned the corner, struck him on the right side, leaving no external evidence of violence. There was a three-inch tear in the right lobe of the liver and a pint of blood in the abdominal cavity. The patient died in the street from hemorrhage before medical aid could reach him.

Mr. Battle (London *Lancet*, 1894) reports a case of rupture of the bile duct in a boy six years of age, who was run over by a hansom cab, in which there was but a slight shock without much pain or tenderness. Vomiting began early and persisted. On the fifth day slight jaundice developed. He was operated upon on the eighth day, and the abdominal cavity was found filled with bile. He died on the morning of the ninth day.

Autopsy.—Liver and gall-bladder were intact, but about one-half an inch beyond the junction of the cystic and hepatic ducts the common duct was found to be torn completely through. No other injury was found.

J. E., aged forty-six, was admitted to the German Hospital on November 17, 1893, suffering from injuries received by being struck by a locomotive. He had a compound fracture of the lower jaw, lacerated scalp wound and fracture of four ribs on the left side, with no other signs of injury. He died six hours later. Post-mortem examination revealed a hemato-thorax of the left side. The peritoneum was not perforated or otherwise injured,

but the peritoneal cavity was filled with blood. The spleen was completely comminuted, and the left kidney had been forced from its bed and was floating in the retro-peritoneal space. There was an extensive hemorrhage between the layers of the mesentery, and a hemorrhagic extravasation of the posterior wall of the stomach.

H. M. C., colored, aged sixteen, was admitted to the German Hospital on the evening of December 3, 1894, with the following history: While playing about some moving freight cars he was accidentally caught between the bumpers, sustaining an injury to his abdomen. Examination upon admission failed to disclose any evidences of external injury. The introduction of the catheter drew clear urine. There was a moderate degree of shock, and the patient complained of severe pain in the abdomen and tenderness on palpation. Further investigation proved negative.

The resident surgeon, Dr. Page, not deeming the case of sufficient severity to send for me, treated the patient for shock. When I examined him upon the following day, it was very evident, from the severity of the abdominal pain and tenderness associated with very decided rigidity of the abdominal walls, that he was suffering from a serious intra-peritoneal lesion. I decided to open the abdomen at once. As soon as the peritoneal cavity was opened a large quantity of dark liquid blood escaped. The small intestines were delivered, when the cause of the lesion was found to be a ruptured mesenteric vein, the bleeding from which was arrested by the presence of a large diffused blood-clot occupying the interval between the layers of the mesentery. To make sure that there was no other lesion, the large intestines, the stomach, the liver and the spleen were carefully examined, but with a negative result. The abdominal cavity was washed out with warm saline solution, glass drainage was introduced into the pelvis and the wound closed. Recovery was uninterrupted.

L. C., male, Italian, aged thirty-five, was admitted to the German Hospital, with a history of a fall of about 50 feet, striking upon his abdomen. He was profoundly shocked and exsanguinated. The only external evidences of injury were some slight cuts on the hands and

head. A diagnosis of internal hemorrhage was made and the abdominal cavity opened up. Dark liquid blood escaped as soon as the peritoneum was opened, and the source found to be the mesenteric vessels. The mesentery was torn half-way across and the intestines lacerated in four places. The mesentery was united with a series of catgut ligatures. The rents in the intestines closed with the Lembert sutures. The abdominal cavity was washed out with hot saline solution and closed. He died two hours after the operation. The autopsy demonstrated several tears in the gut which had been overlooked and several grape-skins and pieces of fig in the peritoneal cavity.

The most common form of intra-abdominal hemorrhage is that resulting from ruptured extra-uterine pregnancy. While these cases may be due to traumatism without any internal evidence, they are usually spontaneous. While hemorrhage from the pelvic organs of the female usually occurs from a ruptured extra-uterine pregnancy, it may be due to other non-traumatic causes. Hematosalpinx may occur independent of pregnancy, and rupture either spontaneously or from traumatism. Again, degenerated blood-vessel walls, and especially veins, may rupture under similar circumstances.

M. E., aged twenty-four, nurse, admitted to the German Hospital January 20, 1893. While lifting a heavy weight from an elevator she felt something give way in her abdomen. This was immediately followed by severe lancinating pain in the right ovarian region. She was menstruating at the time. Pelvic peritonitis promptly set in. An examination demonstrated a tumor in the right broad ligament about the size of a hen's egg. The peritonitis and tumor subsided to treatment, and she made a slow recovery. Diagnosis, pelvic haematocele from rupture of an engorged ovarian vein.

Hemorrhage itself is seldom the cause of death, but associated as it is with shock, the degree of which is out of all proportion to the severity of the accident, it is frequently fatal in a very short time. When the peritoneum is wounded shock is still more profound, the so-called peritoneal shock.

Hemorrhage within the peritoneum is sometimes very slight and distinctly localized, and may occur several times during

the course of the illness. It may take place between the layers of the broad ligament and soon stop from the pressure.

I report the two following cases of hemorrhage from my list of operations for ruptured extra-uterine pregnancies, as they illustrate so typically the wisdom of immediate operation:

Mrs. A. K., aged thirty-one, admitted to the German Hospital September 21, 1894, with the following history. Six months prior to admission she had been subject to attacks of vertigo, pain in the back and limbs, and for the last six weeks to a constant bloody vaginal discharge. Examination revealed a retroflexed uterus with a slight tear of the cervix and the presence of a small movable mass behind and to the left of the uterus.

September 25th, four days after admission, the patient was etherized and the uterus was dilated and curetted. After the operation the discharge stopped, but the patient gained in strength very slowly. She was advised to submit to abdominal section, but preferred to wait until she was stronger. On the night of November 22d she awoke with a severe pain in the right side, and on attempting to walk to the water-closet fainted. After being returned to bed she again fainted and went into a collapse, the pulse becoming almost imperceptible and the temperature falling to 96°. Under active stimulation she reacted. The diagnosis was made of internal hemorrhage from rupture of a probable extra-uterine pregnancy.

The abdominal cavity was found filled with fluid blood and clots and the right tube ruptured. The tube was tied off and the abdominal cavity flushed with hot saline solution, a glass drainage-tube introduced and the wound closed. The patient was not much shocked by the operation, but on the contrary seemed rather improved. The drainage-tube was removed on the third day, the wound healed by first intention, and the patient made a good recovery.

Mrs. J. W., aged thirty-six, was admitted to the German Hospital November 21, 1894, with the following history. About two o'clock on the morning of admission she was seized with a violent pain in the lower abdomen. For this she took some whisky and was somewhat relieved. At nine o'clock the same morning she

started for market and was suddenly taken sick, becoming very weak and suffering from a violent pain in her abdomen. She returned home with difficulty and called in Dr. Hand, who advised her immediate removal to the hospital. At the time of admission she was very weak, and there was distinct tenderness over the abdomen with slight dullness on the right side. Immediate operation was advised and consented to.

When the peritoneal cavity was opened it was found to contain fluid blood and clots. The right tube was the site of a small rupture and was tied off and removed. The abdominal cavity was washed out with hot saline solution, glass drainage introduced and the wound closed. The patient was very much shocked by the operation and reacted slowly. During the operation hypodermatoclysis was practiced. The drainage-tube was removed on the fourth day, the wound healed by first intention, and the patient was discharged, well, on the twenty-third day.

The following case of hemorrhage from ruptured extra-uterine pregnancy illustrates the danger of delay as strongly as did the two previous cases the efficacy of prompt interference:

Mrs. P., aged thirty, was a patient of Dr. S. Cooke Ingraham, of Wissahickon, this city, who furnishes the following history:

I first saw the patient on January 29, 1892. She complained of severe abdominal pains of a bearing-down character and of a sense of fullness in the epigastric region. She had been married seven years, but had never been pregnant and laughed at the possibility. For the past three years the menstrual flow had been decreasing in amount and for several months past had been very scant. The breasts were slightly enlarged, but the areolas were not darkened. The glands of Montgomery were a little more prominent than normal. She had suffered from morning vomiting for the past month.

I was hastily summoned to see the patient on the morning of February 2d, and found her in a state of collapse, pulseless and with a temperature of 96.5° . She reacted to active stimulation and was sent to the German Hospital for immediate operation, a diagnosis of ruptured extra-uterine pregnancy of the tubal variety

having been made. Upon admission her pulse and temperature were normal. She did not complain of pain. Examination of the abdomen and per vaginam and rectum failed to reveal any mass, although a circumscribed area of flatness could be demonstrated low down and to the right side. She continued in this condition until February 12th, when at her own request she was discharged. On February 23d she was readmitted at Dr. Ingraham's earnest request. At the time of the second admission the abdomen was markedly distended, being tympanitic above and flat below. Pulse 116, temperature 101.5° . She complained of considerable pain.

The following day she was operated on, and when the peritoneum was opened a fetus with clots and fresh blood gushed out. The ruptured sac occupied the right iliac region and was tightly adherent to the neighboring coils of small intestines, to the cecum and to the vermiform appendix. After a prolonged and tedious dissection the sac was enucleated; this was accompanied by very free bleeding, which necessitated packing of the cavity with gauze. The wound was closed with the gauze packing *in situ*. The patient died the following day of hemorrhage.

The immediate effects of an injury severe enough to cause a serious lesion of an abdominal viscous are sometimes so slight as to be misleading. Very often a patient with such a condition will walk to a conveyance or to the hospital, complaining only of a slight pain. In varying periods of time following the injury more decided symptoms will develop, viz., signs of hemorrhage if the solid organs be involved and early peritonitis if the hollow viscera be ruptured or torn sufficiently to allow their contents to escape. When this occurs operation is imperatively demanded without delay. This is also true of hemorrhage consequent upon the rupture of an extra-uterine pregnancy, be it traumatic or spontaneous. In ectopic gestation operation will be necessary in every case at some period of its history; therefore if a diagnosis can be made, or even a well-founded suspicion of the condition exists, rupture should not be allowed to occur. If rupture does occur, however, immediate interference is the only certain means of saving the patient's life. The longer the operation is deferred the greater the risk to life. Hasty operations,

often necessitated by the patient's condition, are likewise less liable to reach a favorable termination. Blood-clots or intestinal or gastric contents cannot be washed out of the peritoneal cavity except by prolonged and repeated flushing.

The almost universal fatality of intra-abdominal lesions of traumatic origin is so well recognized that it seems as if there could hardly be any question as to the wisdom of opening the abdominal cavity. I would not be understood as meaning that abdominal section should be used as a means of diagnosis, but on the contrary I believe that every known means, with attention to the most minute details, should be exhausted in establishing a diagnosis. When a diagnosis is impossible abdominal section is justifiable only when it be-

comes the last and only chance for the patient.

I have refrained from using the terms exploratory and diagnostic incisions, believing that they not infrequently serve as a shield to cover a lack of diagnostic ability. It is a moral obligation resting upon every physician and surgeon to develop to the utmost of his ability the highest diagnostic attainments.

Aseptic surgery has undoubtedly been one of the greatest boons to humanity that this nineteenth century has brought forth. But to me it seems that it affords a great temptation to men who have not had experience and surgical training, and who have, therefore, not fully developed their diagnostic skill, to do operations which are not necessary for their patients' good or with a scientific precision.

A CASE OF MALPRACTICE.

P. J. FARNSWORTH, M.D., CLINTON, IOWA.

The Spitz dog of a highly respectable family of this city had a difficulty with his throat. Respiration impeded; deglutition difficult. The carriage was ordered out and Tip was taken to a leading surgeon. The latter diagnosed stenosis or tumor of the larynx in the neighborhood of the vocal cords, as Tip's bark had sailed away and was lost at C.

An examination confirmed this diagno-

sis, and under chloroform an operation was performed. The dog died. At post-mortem examination it was found that some one had slipped over his head a rubber band such as druggists use to tie up packages. It had worked through the hair and bedded itself in the skin. In any case it was the cause of the dog's death, and the bereaved are now querying where to fix the blame.

DEATH FROM URETHRAL INJECTION OF COCAINE.

In this case the patient was aged seventy-two, with heart disease, atheromatous arteries, and subject to angina pectoris. He had also an enlarged prostate, which caused retention. Attempts at catheterization failed, and puncture was resorted to. The next day catheterization having again failed, suprapubic cystotomy was decided on; but a last attempt was made to pass the catheter under cocaine. Twenty grams (!) of a 5 per cent. solution was injected into the urethra. Immediately the patient became pale, general trembling set in, he sat up in bed, commenced to vomit and fell back dead.

In a report on the case Dr. Reclus says that, remembering the absorptive power of mucous membrane, it is not surprising that one gram of cocaine injected into the urethra should cause death, and the large quantity employed was the sole cause in this case. It had already been said down that 15 to 20 centigrams should not be exceeded, and that the solution should not be more concentrated than 2 per cent. It was also pointed out that the recent injury done to the urethra would largely contribute to the rapid absorption that evidently took place.—*La Sem. Med.*

TRANSLATIONS.

THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

SALICYLIC ACID BY THE RECTUM.

Dr. Erlanger (*La France Médicale*, No. 1, 1895) from experiments on a large number of rheumatic patients at the Munich Hospital, finds that one may employ rectal injections of solutions containing salicylic acid with advantage in treating this disease. Absorption, he has observed, is somewhat slower by this method, though the results are as satisfactory as when given by the mouth. He sets forth the following rules for its administration:

The rectum should first be emptied by a preliminary injection; the solution should be lukewarm. The most convenient formula is the following:

Salicylate soda.....	6-8	o	5 jss-ij
Tr. opium.....	1	o	gts. xv
Water.....	100	o	3 ij 3 j

The solution should be thrown high up into the bowels by means of a rubber oesophageal sound attached to a syringe. The patient must be instructed to retain the clyster.

TREATMENT OF SYPHILIS IN CHILDREN.

Dr. J. Simon (*Revista de Ciencias de Medicas de Barcelona*, No. 23, 1894) with regard to prophylaxis, recommends advising against matrimony in subjects with contagious primary and secondary symptoms; to require a free after-period of at least twenty months, during which there are no visible syphilitic symptoms; to prohibit marriage in those with rebellious tertiary symptoms with visceral lesions. During the pregnancy of syphilitic mothers, administer mercury in small but continuous doses. Recommend nursing energetically, for "a woman who has brought forth a syphilitic child will not be infected by her child during nursing" (Colles' law). In case of impossibility, seek a syphilitic nurse, but never give it to one who is healthy. In case of necessity feed with mother's milk by the bottle. In children of five to six weeks, give during the day Van Swieten's solution, 20 gts.

four times a day in milk. At the same time give inunctions of mercurial ointment (0.50:2.) morning and evening. One inunction a day will, however, suffice. On going to bed is the best time. Change the regions where applied from one side to the other. This treatment should not, as a rule, last longer than four weeks. The dose of Van Swieten's solution may be decreased, increased or interrupted from time to time. Indirect treatment may be instituted by administering the mercury to the mother or nurse. If she be syphilitic, then give her the iodide of potash and apply mercurial ointment by inunction to the child. In case of protuberant osseous tumors, apply Vigo's plaster. Separation of an epiphysis requires fixation in an immobilizing bandage until consolidation takes place. If it has completely separated from the rest of the bone, then remove it as if it were a foreign body.

FRESH MEAT-JUICE IN DISEASE.

Professor v. Ziemssen (*Wiener Medizinische Presse*, No. 52, 1894), the celebrated clinician of Munich, speaks very highly of freshly expressed meat-juice as a food in disease. Those patients who find the bloody taste repugnant, may easily have 'his disguised by adding a little brandy and extract of vanilla with sugar, and upon freezing it an agreeable ice-cream is formed which is eaten by the most fastidious with pleasure. In this manner administered there will be no difficulty in giving a patient at least 200 grams (3 vjss) of the juice, and, indeed, even to those patients who have a disgust for all other forms of food or who cannot retain food, as typhoid cases.

CHLOROFORMIZATION BY THE DROP-BY- DROP METHOD.

Dr. C. G. Bremer (*Vratch*, No. 52, 1894) communicates the results of his experience with the drop-by-drop method in administering chloroform as an anesthetic in 1,000 cases. He concludes that anesthesia is much less disagreeable for

*In charge of the translator, F. H. Pritchard, M.D.

the patient; excitement is less frequent; the patient comes more quietly under the influence of the anesthetic, and vomiting is less frequent during its administration. The quantity of chloroform required for complete anesthetization of an adult, is between 17.5 and 21.5 grams instead of 100-200 grams as by other methods. He has found that the anesthetic may be continued for several hours without danger; vomiting, headache and other disagreeable symptoms following awaking are less frequent, while accidents are infrequent.

STROPHANTHINE.

Professor v. Ziemssen (*Muenchener Medicinische Wochenschrift*, No. 50, 1894) says that strophanthine, though not so lasting in its action as digitalis, is preferable to the tincture of strophanthus as a substitute for digitalis; both, in the tincture, had best be cast out of the Pharmacopoeia on account of their unreliability. Digitalis he would have used only in infusion or powder. Strophanthine is not cumulative in its action. He administered it in a dose of 0.001 ($\frac{1}{4}$ gr.) twice a day.

OINTMENT OF RED OXIDE OF MERCURY IN VARICOSE ULCERS.

Dr. H. Langes (*Muenchener Medicinische Wochenschrift*, No. 48, 1894) speaks highly of treating varicose ulcers of the legs with an ointment of the red oxide of mercury. The officinal ointment he has found to be too strong (one part of the red oxide of mercury to nine of vaseline), so that he mixed it with one to two parts of vaseline. The influence upon suppurating wounds was apparent in a short time, not only upon suppuration, but also upon the development of healthy granulations. The first day the patient usually complains of violent pains, which by the third have entirely or nearly disappeared; at the same time the bottom of the ulcer will assume a healthy appearance and vigorous granulation and cicatrization will follow. With the mixed preparations of the ointment the reaction was less violent, but healing also took place, but less rapidly. The dressing should be renewed once a day and the salve be spread upon a piece of cloth to the thickness of a knife blade; a flannel or small bandage may be

used to wrap the extremity. Rest in bed will accelerate the healing process.

TREATMENT OF TAPEWORM.

Professor Potain (*L'Union Médicale*, No. 30, 1894), in a lecture on the tape-worm and its treatment, among the long series of remedies which have been proposed finds but few which are actually reliable. They may be divided into indigenous and foreign; among the latter are kousso, musenna and kamala. Kousso is an excellent remedy, but it is so easily altered that it is of not much practical value. The male fern, an indigenous remedy, is especially employed in expelling the bothrioccephalus. The ethereal extract is used as well as the powder and the decoction. One may administer 2 grams (grs. xxx) of the ethereal extract mixed with 3 grams (grs. xlvi) of the powder, after which one may take a decoction of 3 grams (grs. xlvi) of the powder in 100 grams ($\frac{3}{2}$ iiij 3 j) of water. Two hours after 2 ounces of castor oil are given. In certain cases pumpkin seeds will yield good results; those of the *cucurbita maxima* are best used, as the smaller varieties are harder to obtain and give less satisfactory results. Take 250 grams ($\frac{3}{2}$ viij) of the seeds, which after extracting the kernels will leave about 50 to 60 grams of hulled seeds. These are rubbed up with sugar to form a paste, or with milk to make an emulsion. The evening before the patient should be put upon a milk diet and the seeds ingested the following morning. Two hours after follow with a purgative. Squash and gourd seeds are only indicated in individuals with susceptible digestive tracts; they will yield but uncertain results.

The true and most efficacious remedy is the bark of the roots, trunk and young branches of the pomegranate; the dose is 60 grams ($\frac{3}{2}$ ij) of a not too old bark, which is macerated for twenty-four hours in 750 grams ($\frac{3}{2}$ xxijss) of water, which is later reduced by slowly boiling to 500 grams ($\frac{3}{2}$ xvss). This should be taken in two portions, with an interval of ten minutes, and then followed with 60 grams ($\frac{3}{2}$ ij) of castor oil as soon as the patient feels a little motion in the abdomen. If the oil be given too early, the worm will not have been stupefied; if too late the head will remain. This drug may cause vertigo and

roaring in the ears, which symptoms are still more prominent with pelletierine, a glucoside extracted by Tanret. The sulphate is usually employed, but it has the inconvenience of being absorbed by the stomach and in acting upon the patient and not upon the worm; therefore Tanret has mixed it with the sulphate of tannin to retard absorption. The patient, from the evening before having been upon a milk diet, takes 30 cgms. (grs. ivss) in two doses, with a half-hour of interval; then after about an hour a purgative is administered. If this does not act, a purgative rectal injection is indicated. Out of 100 cases, one will obtain successful results in about 79. This alkaloid also gives rise to vertigo, roaring in the ears and a sort of very marked "drunkenness." All these symptoms will be less intense if one take care to keep the patient in bed. In case of failure do not repeat the remedy until the sections reappear in the stools. It seems, in some cases, as though the worm became accustomed to this drug.

A CASE OF TETANUS IN A PREGNANT WOMAN.

Dr. Augustin (*Spitalul*, No. 17, 1894) recently reported the case of a woman who, in the seventh month of pregnancy, suddenly developed tetanus after taking cold, and who was cured spontaneously in a month. Pregnancy was not interrupted, and she was delivered of a healthy child at full term. He proposed premature labor, but she refused and was taken from the hospital after receiving a few rectal injections of chloral and the bromide of potash, together with two hypodermics of pilocarpine. At home, in the country, she recovered without any treatment beyond rubbing her head with brandy. He calls attention to the possible gravity of this disease for both mother and child.

FEVER OF TUBERCULOSIS IN CHILDREN.

Dr. Rachford (*Covremennaya Klinika*, No. 10, 1894) in treatment of the fever of tuberculosis, and particularly that of the lungs, in children, advises the following salve:

Guaiacol	55	4	0	5
Lanoline				
Lard	30	0	5	

Rub a little of the salve of the size of a hazel-nut into the region of the chest each evening.

TREATMENT OF NEURALGIA.

Professor Dujardin-Beaumetz (*Revue Internationale de Médecin et de Chirurgie Pratiques*, No. 17, 1894) recommends the employment of antipyretics which are at the same time analgesic. Phenacetine may be given in doses of $\frac{1}{2}$ to 1 gram (grs. vijss-xv) in two to three powders in twenty-four hours. In migraine, antipyrine is to be preferred; in lightning-like pains, pains from pressure and pains of dental origin, give acetanilid. In essential neuralgia, exalgine is preferable. Phenacetine is of greatest service in the painful affections of neurasthenic and neuropathic subjects. Antipyrine may be administered in doses of 1 to 4 grams (grs. xv-3j) in twenty four hours, either in powder or in a grog. The fulgurant pains of tabes are best controlled by acetanilid. Give 1 $\frac{1}{2}$ grams (grs. xxijss) in three powders during twenty-four hours.

BICHROMATE OF POTASH IN GASTRIC AFFECTIONS.

Professor Fraser (*ibid.*) has employed bichromate of potash in 18 cases of simple dyspepsia, and 10 cases of ulcer of the stomach, in doses varying from 5 mgms. to 1 cgm. ($\frac{1}{2}$ gr: 1-6 gr.) three times a day, either in pill form or in a watery solution to which has been added a little syrup of tolu or orange and taken before meals. A few days after its use, all the dyspeptic symptoms, the pains, nausea, vomiting, etc., decreased in severity or disappeared completely. He rather ascribes the results to a particular action upon the gastric mucous than to any antiseptic influence.

INDICATIONS FOR COLD BATHS IN DISEASES OTHER THAN TYPHOID.

Dr. Wiart (*Gazette des Hôpitaux*, No. 50, 1894) sets forth the following indications for cold baths in various diseases, not including typhoid fever:

General indications—

1. When the urine is scanty, dense and charged with albumin.
2. When there is elevation of temperature.
3. When there are grave nervous symptoms even without high temperature.

4. When the heart is failing.

Special indications—

1. In erysipelas and particularly in the severe and typhoid forms. Cold water will not arrest the course of the disease, but it will calm the pains, reduce the nervous symptoms and shorten the period of convalescence. Renal complications give a second indication especially.

2. Small-pox is a disease where writers disagree as to indications. Vinay and Juvel-Renoy administer cold baths from the beginning, thus claiming a decrease of severe symptoms and find no contraindication in the eruption. But Vinay, after suppuration commences, only employs a bath of 28° C. Clement only begins to give baths at this period. In the hemorrhagic form the results were nil; in the confluent and coherent varieties the mortality was lowered.

3. Scarlet fever in the adynamic or atonic forms is only to be treated by cold baths. Renal, cardiac, pulmonary, articular and hemorrhagic complications do not contraindicate.

4. Measles are only to be treated thus in the anomalous forms.

5. Pneumonia and broncho-pneumonia in France are thought only exceptionally to be treated by cold baths. In children, when the general symptoms become serious, they will possibly sustain the patient and lower the temperature, yet they are not curative measures.

6. In cerebral rheumatism in the acute form it is the only efficacious treatment; in the apoplectic variety it is without effect. Put the patient into very cold baths, repeat them frequently and prolong them; massage energetically and give alcohol in generous doses. Thus one may lower the temperature from 42° to 37° C. in forty-eight hours. Montagne and Amblard have also treated cerebral gout with high temperature by cold baths with success.

7. Puerperal fever requires the cold bath in the acute septicemic forms with typhoid symptoms.

8. Exanthematic typhus, when there are high temperature and general nervous phenomena, necessitates these measures.

9. Finally, cold baths have been employed with success in grippe in a malignant form, tetanus, infectious icterus, hepatic colic with profound adynamia, and nephritis.

IS THE BABY TONGUE-TIED?

Dr. Chervin (pamphlet, Paris, 1894), the director of the Institute for the Treatment of Stammerers at Paris, has made an interesting study of the surgical aspect of this subject. Much performed in certain regions of France and formerly often done by some of the greatest surgeons, he thinks that its use has a very limited application; for example in those rare cases where the tongue is bound down to the floor of the mouth by an inferior ankyloglossia so that the tongue is immobilized. In certain cases where the frenum is too long and by extending even to the tip of the tongue interferes with nursing, then not a mere incision, but an excision is required. This is exceptionally necessary, and though in itself insignificant, it may present serious danger in a little child. It is wrong to think that if an infant nurses badly its frenum must be cut. A little exercise upon the end of one's finger will correct this fault and operative interference will be unrequired. Cutting the frenum is absolutely useless in correcting defective pronunciation, for this is only to be remedied by a methodic education of the voice by natural and rational exercises which will not exceed three weeks.

OBLITERATION OF THE SUPERIOR VENA CAVA AND ITS TREATMENT.

Dr. F. Merlin (*La Loire Medicale*, No. 4, 1894) records an interesting case of a man of thirty-four years, who presented all the classic signs described by Oulmont as characteristic of obliteration of the superior vena cava—œdema of the face, neck and upper portion of the thorax, but which was less marked in the arms; cough and attacks of dyspnoea, cyanosis, vertigo, headache and signs of cerebral congestion. He was put upon antisiphilitic treatment, 4 grams (3 j) of the iodide of potash a day, with local application of iodine to enlarged glands at the root of the neck behind the sternal fascia. Though the patient denied having had syphilis, the result confirmed the suspicions which were verified later. In one month all the symptoms were relieved; the œdema, cyanosis, dyspnoea and the accompanying deafness were cured and remained so definitely, as the writer was able to observe four years later.

INSUFFLATION OF AIR IN TUBERCULOUS PERITONITIS.

Dr. Folet (*Le Nord Medicale*, December 15, 1894) treated a case of tuberculous peritonitis with ascites by puncture, evacuation of six quarts of serous fluid and insufflation of three quarts of air, which method had been proposed some time ago by Mosetig Moorhof, of Vienna, with the difference that this writer advised injecting filtered air, while in the former case the air of the room was insufflated unfiltered. A recovery followed which has endured for nine months. It has been suggested to employ a similar procedure in tuberculous pleurisy.

TREATMENT OF ANGINA PECTORIS FROM TOBACCO.

Dr. J. Crook (*Le Semaine Medicale*, No. 1, 1895) recommends for the treatment of angina pectoris in tobacco-users, the following preparation:

Alcoholic solution trinitrine, 1 p. c. gtt. xv
Pl. extr. cactus grandiflorus. 8 | 0 5 ij
Hoffmann's anodyne. 2 | 1 3 v gtt. xv

Sig.: Thirty drops three times a day in a little water.

If necessary the dose may be increased gradually to sixty drops.

IODINE AND SALICYLIC ACID IN DIPHTHERIA.

Dr. Kersch (*La Semaine Medicale*, No. 1, 1895) claims as good results as with the antitoxine treatment, with the following formula in diphtheria:

Iodide sodium.....	3 0	grs. xlv
Salicylate soda.....	5 0	5 ij-4
Water.....	200 0	3 vi 5 ij
Raspberry syrup.....	30 0	8 j

Sig.: A tablespoonful or two, if there is great urgency, every hour.

Out of 17 cases treated thus he lost 3. He excludes 2 cases where treatment commenced when there was intense cyanosis with orthopnoea and cardiac weakness. Under the influence of this treatment the false membranes were rapidly thrown off, and they gradually ceased to reappear. There is no danger of serious iodic symptoms.

A New Operation in Internal Hemorrhoids.

Dr. Janes (*Provincial Med. Jour.*) reports a new method for treating internal hemorrhoids by means of a clamp and suture instead of the cautery. After dilating the sphincters he seizes each hemorrhoid and applies the clamp to its base, cuts away the pile and approximates the mucous membrane of the stump with catgut sutures as follows: The ligature is threaded with two needles. Beginning at one end of the wound, one needle is made to transfix each side of the mucous membrane; then by means of a double continuous suture the surfaces are united with a cobbler's stitch, and in addition each time the needles are drawn through an over-knot is tied. This form of suture is unique, as it prevents any possible bleeding and greatly lessens the risk of the deeper part of wound becoming infected.

Flatulence.

For flatulence in children Ringer recommends:

Tinct. asafoetidae.....	fl 5 ss
Aq. destill.....	fl 5 ij
M. Sig.: A teaspoonful every hour or two.	

For flatulence due to fermentation:

Acidi sulph.....	fl 5 jss
Syr. zingiberis.....	fl 5 vjss
Aq. destill.....	fl 5 j
M. Sig.: A teaspoonful.	

Influence of Habitual Inclination of Pelvis on the Pelvic Canal.

Hirst (*University Medical Magazine*) points out that although the pelvic obliquity on account of its normal variations can generally be neglected in regard to childbirth, the influence of habitual inclination of the pelvis on the development of the pelvic bones and pelvic canal has been neglected. Exaggerated inclination of the pelvis in childhood so that the trunk weight is received by the sacrum increases the forward rotation of that bone, diminishing the antero-posterior diameter of the inlet and the depth of the canal, while excessive action of the rotator muscles of the thigh tends to widen the outlet. On the other hand, if the pelvic inclination is diminished, the top of the sacrum is pushed backward, the antero-posterior diameter of the inlet is increased, as is also the depth of the canal; while pull on the ilio-psos muscles, separating the iliac bones apart, and by compensatory displacement of the ischia, narrows the transverse diameter of the pelvic outlet.

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SATURDAY, FEBRUARY 9, 1895.

EDITORIAL.

THE CHOICE OF AN ANÆSTHETIC.

The precise clinical value of any anæsthetic is settled by the practitioner or clinician and not by the experimenter. Unfortunately for the profession, the controversies as to the relative values of the different anæsthetics and which should be the one of choice from the standpoint of both safety and effectiveness, is largely due to uncertain utterances coming from laboratories. The relative clinical merits and demerits of the anæsthetic agents commonly in use, have long since been settled by active surgeons.

The early and free general use of chloroform resulted in precise knowledge of its risks and its great value in the hands of trained surgeons. Chloroform was and is safely used by trained anæsthetizers. Accidents, which are not common, are usually due to culpable carelessness and ignorance. The general, almost exclusive, use of chloroform by two of America's most prominent surgeons, Gross and Hunter McGuire, should go farther in settling

the problem and should have more weight than the opinions of all mere experimenters whose notions, not experiences, find conspicuous place in medical literature.

The surgeon who knows it, and uses it night and day in the most difficult operations, has a right to speak plainly as to its great value, for he voices the lessons of his own work, the results in his own professional experience.

The laboratory practitioner, destitute, as he usually is of clinical and applied knowledge, is not a reliable authority, and in many instances has worked mischief. It is the man who has done and does put an anæsthetic to repeated practical tests, who can speak with the best authority.

Smothering cats or dogs with either chloroform or ether, paralyzing heart or respiratory centres; or water-logging kidneys or lungs in the human subject, is not surgical anæsthesia. Animal experimentation does not furnish a safe guide, for

here the anæsthetic is pushed to the point of death, or, where not, the conditions maintained furnish little of value in the line of surgical teaching. Any anæsthetic that deadens sensation, or paralyzes the respiratory or circulatory centres, if ignorantly or carelessly pushed beyond perfect anæsthesia, will kill.

Chloroform may be, and has been used for prolonged and complicated operations in feeble, exhausted and anemic patients, without accident or unfavorable results. Commonly ether also can be prolonged without working mischief. Facts demonstrate that the lack of clinical knowledge prevents their absolutely safe use. About all recorded accidents, and the very many unrecorded, have been largely due to ignorance and inexperience. The number of deaths ultimating from the use of ether is probably greater than that of speedy deaths occurring from chloroform. A number of the deaths occurring in the first five or ten days following an operation, from pneumonia, edema of the lungs, suppression of the urine, etc., are directly chargeable to a reckless use of ether. Rarely is anything said about the anæsthetic being the primary cause. The timid apprehension of the profession favors the use of ether. It dreads accidents and still more that censure, professional and from without the profession, which follows sudden death. It must be granted that sudden death often occurs aside from the anæsthetic; shock, hemorrhage and other conditions must be taken into account. The profession knows perfectly well that chloroform kills quickly.

There is, in certain sections of our country, a very strong prejudice against chloroform, arising largely from the fact that the administration of the anæsthetic very frequently falls to the hands of untrained, inexperienced and incompetent men, thus greatly augmenting the risks. A surgeon who wishes to avoid anxiety must put either chloroform or ether in the hands of an experienced and thoroughly com-

petent anæsthetizer. To be such requires long experience. A patient once under its influence can be kept safely for an hour with from two or three ounces of ether. Where complications accompany surgical conditions, many of our most successful surgeons make ether their choice, and find its administration by cautious and trained hands absolutely safe.

It is generally accepted that the surgeon should use that anæsthetic with which, in his practice, he has grown most familiar, and in the use of which he has had immunity from accident. Statistics in this connection are not reliable. In discussing the subject, Dr. Hunter McGuire, of Richmond, Va., who held an eminent position* in the Southern army, and to-day is equally eminent among the surgeons of our country, says, in answer to the statement that statistics show that chloroform kills one in three thousand; ether one in ninety thousand: "We have no data or figures by which we can make such statements as to the number of deaths from chloroform and ether, and the number of times each anæsthetic has been given. So far as I am personally concerned, I think chloroform is safe as a rule, but we should select our cases. I venture to predict that when the experience of the civilized world is collected and analyzed, it will be found, if indeed it is possible to definitely settle such a question, that in certain cases ether should be given, and in certain other cases chloroform should be employed, and that every good surgeon will be expected to exercise discrimination in the selection of his anæsthetic. For myself I am wedded to neither of these agents. In general terms, in feeble, anæmic people, those suffering from the prostration of shock or loss of blood, I prefer ether; in either the young or the old, or in cases where cardiac, renal, or pulmonary trouble is suspected, as a rule I think chloroform is safer. That both agents sometimes kill the patient, the

most bigoted and partisan advocate of either ether or chloroform must admit. But which of the anæsthetics is more dangerous and apt to kill, is the paramount but undetermined question. I know I am within bounds when I say I have given chloroform 12,000 times; I give ether too. I think every good surgeon should select his cases. No one has a right dogmatically to give one or the other anæsthetic."

Bearing upon the subject we quote from Dr. Hamilton's "Legal System of Medicine."

"Ether the Anæsthetic of Choice.—We must be forced to the conclusion, in making selection of an anæsthetic, that ether, where it can be employed, is the anæsthetic of choice. Since Wunderlich has shown that the immunity from renal sequelæ formerly supposed to exist in chloroform narcosis has no foundation in fact, the last argument in favor of the employment of chloroform in place of ether, when the latter is not positively contraindicated—as, for instance, by actually existing pulmonary conditions or in intracranial operations, in which class of cases ether seems to increase, while chloroform decreases the cerebral congestion; and in certain operations about the mouth and face where the galvano or thermocoagulatory must be used or the mask frequently removed in the progress of the work—falls to the ground, when statistics showing the unquestioned safety of this anæsthetic agent as compared with chloroform are considered.

"A collection of yearly reports of narcosis covering 62 reports, making a total of 61,526 cases, shows after the deduction of 11,464 cases of nitrous-oxide anæsthesia, that there were 11 deaths in the remaining 50,062, or one in 4551 cases.

"The number of cases of anæsthesia collected during the past three years amount to 161,800, in which number there were 52 fatal cases, or one death in 3111 cases. Of 133,729 cases of chloroform anæsthesia there were 46 deaths, of one in 2907 cases. In 14,646 cases of ether narcosis there was not a single death. Of mixtures of chloroform, ether and alcohol (Billroth's) show in 3440 cases no fatality. In 4555 cases of bromide-of-ethyl anæsthesia there occurred one death. Of 597 cases of pental anæsthesia 3 were fatal.

"To sum up, therefore, it may be said that every patient to whom an anæsthetic is administered takes thereby some risk, but that this risk is less in ether than in chloroform narcosis. Each possesses especial advantages, but those claimed for chloroform relate chiefly to convenience, while those claimed for ether relate to comparative safety. The warning signals of approaching danger in ether can be recognized before the patient is beyond recall; in chloroform he is frequently already within the valley of the shadow of death before the anæsthetized is aware that anything is wrong. The surgeon, therefore, who at the present day selects chloroform as the anæsthetic of choice would do well to fortify himself with facts to show that ether is contraindicated in the particular case; otherwise the accusation may be made that an unnecessary risk was assumed in employing chloroform rather than ether, the patient dying from indubitable chloroform narcosis.

"More skill is required to produce ether narcosis than chloroform narcosis; more skill is required, also, to prevent the patient from dying from

chloroform than from ether. An indifferently skillful anæsthetizer can easily kill a patient with chloroform, but he will not be able to anæsthetize properly with ether, much less destroy the patient without some warning which the operator himself would be likely to observe. With blood before him of a healthy hue, and the rhythm of regular and full respirations in his ears, the latter will feel safe as he proceeds in his work, if ether is used. Either of these failing, a word of caution to the anæsthetizer suffices to correct the undesirable condition. But if chloroform is employed the experienced operator knows only too well that the dark blood and absence of respiration mean that the heart has failed in its action, perhaps for several seconds or a considerable fraction of a minute before the dark blood and failing respiration occurred, and from this time on the most vigorous efforts must be made, with the chances greatly against him, to rescue the patient from death.

"Frequent attempts to punish surgeons for deaths occurring while an anæsthetic is being administered tend to damage, not only the profession, but society at large. The great benefit which humanity has received from the use of these agents has been in danger of being nullified by fear on the part of the administrator, not only of damage to his professional reputation, but of being punished as well. Owing to the difficulties of excluding other causes of death in a particular case, fatal narcosis is not easy to establish. This is particularly true where the operation has advanced sufficiently far to allow the element of shock to enter into the case. Reflex irritation of the cardiac centers, giving rise to lessened force combined with acceleration and intermittency, this eventuating in the arrest of the heart's action occurs especially when chloroform is administered. The sudden breaking up of adhesions within a joint, or dilatation of the anal sphincters has not infrequently been followed by the development of dangerous symptoms. Where the element of shock enters largely into the condition there can be no question as to the freedom of the surgeon from responsibility in the sudden collapse.

"Renal affections may result from either chloroform or ether. Contrary to what has been generally supposed, Wunderlich has shown that the latter agent is not alone in its supposed damaging effects upon the kidneys. From his extended observations of the effects of the two anæsthetics upon the renal organs, he makes the following deductions: (1) An already existing albuminuria is often increased by etherization. (2) Albuminuria can be caused by narcotization with both chloroform and ether, but more frequently with chloroform. With the latter this resulted in 11.5 per cent. of the cases; with ether it occurred in only 6.9 per cent. (3) Casts appeared in the urine after both chloroform and ether, but more frequently following the former. This occurred after chloroform in 34.8 per cent. of the cases, and followed ether in 24.6 percent. of the cases. (4) When casts are already present, both ether and chloroform have the effect of increasing the number. It follows, therefore, that both anæsthetics must be used cautiously, as both have the power of setting up degenerative changes in the renal epithelia.

"According to Bardeleben, excitement and fear before and during the administration of the anæsthetic do more harm than the latter, whatever its nature.

"When accusations are made that unusually large quantities of the anæsthetic agent have been used it would be well to bear in mind Mair's statements bearing upon this point. The author states that patients have inhaled 160 grams of chloroform in seven hours; 1028 grams in twenty-four hours in another case; in another, suffering from tetanus, 700 grams in twenty-four hours; in another 1000 grams in twelve hours; a woman in the puerperal state remained chloroformed for thirteen hours, 200 grams being used."

ABSTRACTS.

RECENT VIEWS ON SEA SICKNESS.

In a review of this subject by Dr. Skinner (*New York Medical Journal*) the author comes to the following conclusions:

1. The principal symptoms of naupathia result from the lowering of the patient's arterial blood pressure. This is a condition *sine qua non* of their development.

2. Seasickness in a person otherwise healthy and not too aged is promptly curable in the vast majority of cases.

3. Even in aged persons, or in persons having certain affections of the circulatory apparatus, there is often amelioration of the general condition by the employment of the new method of treatment.

4. The treatment consists in the hypodermic injection of from half a milligramme of atropine sulphate, associated with a milligramme of strychnine sulphate (or nitrate) dissolved in a cubic centimetre of distilled mint water.

5. The administration of these eminently toxic substances demands a great degree of attention, prudence and supervision on the part of the physician, who alone should be the judge of the opportunity of their administration and of their dose in each individual case. Given at proper times and in suitable doses, however, no harm whatever will follow their administration.

6. The sympathetic nervous system plays a preponderating role in the causation of naupathia.

7. Naupathia, or seasickness—an affection without known anatomical lesions, and of which the predominant symptoms have their origin in the nervous system, and especially in the sympathetic or ganglionic nervous system—ought to be regarded as a neurosis of the sympathetic.

8. This neurosis may recur during the course of a long voyage, but each attack is almost always amenable to the same treatment.

SALOPHEN IN DISEASES OF CHILDREN.

Dr. Richard Drews (*Allg. Medizin. Central-Zeitung*) has treated with salophen 15 cases of acute articular rheumatism in children varying from 7 to 14 years. In 5 cases one or both knee-joints were affected, in 4 both ankles, in 4 both shoulder joints, and in 2 all the joints of one side of the body. The remedy was administered in accordance with the age in doses of 0.3 to 0.5 gm. every 2 hours, and 3.0 to 5.0 gm. pro die, and in no instance was any influence upon the heart noted. In the majority of cases the pains were already relieved on the first day and vanished completely at the end of 3 or 4 days; the temperature always fell to normal in the course of 3 or 4 days coincidently with the subsidence of the swelling. In 12 out of the 15 cases profuse perspiration occurred about half an hour after the exhibition of salophen which, however, had no

effect upon the general condition. Aside from this no after effects of any kind were observed. An extension of the affection from one joint to another did not occur; in 2 cases, however, 3 or 4 days after subsidence of the swelling a recurrence ensued which again disappeared after 3 days' use of the remedy. Salophen therefore has the same effect in acute articular rheumatism as salicylate of soda, while free from its unpleasant sequelæ, such as gastric disturbances, tinnitus, vertigo, cardiac depression. An equally satisfactory result was obtained in 5 cases of severe acute muscular rheumatism of the muscles of the neck in which a cure was effected at the end of 3 days. In a case of purpura rheumatica in a girl of fourteen years old, salophen in 0.5 gm. doses every 2 hours also had a favorable action upon the pains, fever and eruption. A

case of chorea is reported in which under administration of 5.0 gm. doses pro die for 12 days the choreic movements, as well as a coincident systolic murmur, disappeared completely. As an antipyretic salophen proved serviceable in various febrile diseases, typhoid fever, scarlatina, pneumonia, tuberculosis, acute tonsillitis, the temperature being reduced 1.5 to 2 degrees C. in the course of half an hour. As an antineuritic it acted admirably in a number of cases of migraine in children

varying in age from eight to thirteen years, the pains being completely relieved by 2 or 3 doses of 0.3 to 0.5 gm. On the ground of his experience Drews therefore concludes that salophen is an excellent remedy in acute articular rheumatism, deserving preference over all other drugs in pediatric practice, that it is a useful antipyretic and an excellent antirheumatic. It was always well borne, and being tasteless can be administered without difficulty.

BOILING WATER—TREATMENT OF SURGICAL TUBERCULOSIS.

This treatment which was originated by Professor Jeannel about one and one half years ago, has since been employed by him with success, in cases of surgical tubercular disease, comprising ulcerations and abscesses of soft parts, as well as lesions of the bones and joints. Dr. Bauby, Professor Jeannel's *chef de clinique*, describes the procedure as follows: When one has to deal with an abscess of the parts or a lesion of the bony tissue, the tubercular focus and the fistulous canals are opened, and in an operable case of tubercular affection of the joints, typical resection is first performed. All the caseous products and granulations are carefully removed with the curette, the cavity is sponged out, and the blood completely staunched. In the meantime salt water has been kept boiling in a can of some sort (coffee-pot, tea-kettle or samovar), provided with a long spout or faucet, to which is adapted a long rubber tube with a pointed stopcock at its other free end. The jet is then turned on and, after the first contents of the tube have been allowed to run away, in order to heat the latter, the tubercular cavity is filled up with boiling water. The water is removed by sponging, after which the cavity is again filled with boiling water and emptied anew. This process is continued until the surface has been sufficiently cauterized.

A better procedure of boiling water treatment consists in pouring into the cavity cold or tepid water, and then heating it to the boiling point by insertion of the red-hot point of the thermocautery, the heat being maintained by continuously working the pump. One minute is suffi-

cient to boil in this manner the water contained in the abscess, the size of a pigeon's egg. The water rapidly evaporates, leaving the cavity nearly empty. This process is repeated four or five times in succession. It is hardly necessary to say that, whichever method of boiling water treatment be employed, general anæsthetization is indispensable, except in cases of very small abscesses, in which cocaine anæsthesia may suffice.—*Med. Week.*

For Acute Coryza.

The *Medical Fortnightly* gives this formula for acute coryza:

Morphina sulph.....	gr. j
Cocaine hydrochloratis.....	grs. iii
Menthol.....	grs. vii
Pulv. acidi borici.....	gr. ii
Bismathi subnitratis.....	gr. ii
Pulv. benzoini.....	gr. ii

M. Sig.: Snuff a pinch up the nostrils several times daily.

Alumnol in Dermatology.

Dr. J. Abbott Cantrell (*College and Clinical Record*) says: "Alumnol has proven itself of decided advantage in my service at the Philadelphia Polyclinic, where I have advised its use in a hundred cases. It was found serviceable in acute vesicular eczema, erythema intertrigo, chronic eczema, non-syphilitic ulcers, ringworm and impetigo contagiosa. It was used in the form of powder, 1 part to 3 parts of starch, and as an ointment in strength varying from 20 grains to 2 drams to the ounce, and as a solution in the proportion of 2 drams to the ounce of water."

KEELEY CURES.

In *The Christian Advocate* of July 26, 1894, ministers and physicians among our readers were asked to assist us in obtaining accurate and impartial statistics of the results of the so-called Keeley cure of drunkards. The public has often been assured that ninety-five per cent. of the persons treated in the Keeley cures are cured or reformed, and that relapses are few. We stated that of those we had met four have relapsed, two committed suicide, and several others were in asylums; the sum total of these being more than fifty per cent. of the small number that we chanced to know. But as that might be true, and the statements made by the agents and managers of Keeley cures, who deal with a large number, might also be true, we deemed the subject of sufficient importance to collect statistics upon it.

The number of persons who have been inmates of the various Keeley institutions is large and scattered through all sections. So far as we can ascertain, at least seven thousand ministers and fifteen hundred physicians, distributed over the United States and in foreign countries, are among our subscribers.

Our plan was this: We addressed three questions exclusively to ministers and physicians:

1. How many do you know who have taken the Keeley treatment?

2. Of those who have taken it, how many, to the best of your knowledge and belief, have remained sober and totally abstinent for a period of nine months or more?

3. How many have relapsed in less than that time, or have committed suicide, or become insane, or have been physically seriously injured by the treatment?

The explanation accompanying these questions were as follows:

Except in the case of personal acquaintances, we do not ask for information from subscribers in general because we would have no way of preventing the duplication of returns. By confining it to ministers and physicians we get one or two persons in a locality, and can correspond with them as to whether they have duplicated.

We wish no information from agents or managers of "Keeley cures" or graduates

thereof. The former are excepted because of their business interests; the latter, because in that case we should get repeated information from the same locality. Neither do we wish mere hearsay information from ministers or physicians. If A tells B that he knows C; that C was a drunkard and was cured by a Keeley institute, and has never touched a drop of liquor since, and B tells us about it, it is of no value in this case. Nor do we wish names, but on the honor of a minister or physician we merely wish, as stated above, the number that he knows to have taken the Keeley cure, and what were the results. Nor do we wish this inquiry to be confused with any other "cure." Since Dr. Keeley began to be noted and to make vast profits, scores of imitators have sprung up, as is always the case; and he has a number of times declared that his institutes have been traduced by the fact that other graduates, who have lapsed, have been charged to them.

We will tabulate and publish the returns.

No sooner had this proposition been made than the Keeley Company sent us a long document denouncing our method, and containing severe attacks upon physicians, and indirectly upon ministers, as prejudiced persons whose testimony could not be relied on. This they say we may publish if we see fit, which we may do when we present the results. It will at least afford to the reader an opportunity of judging whether our exclusion of the company as a source of information was wise or unwise.

Various Keeley Leagues and Auxillary Associations passed resolutions accusing us of being prejudiced and declaring that our method of securing information is not adapted to elicit truthful returns. In various parts of the country circulars were sent to our ministers, urging them to be very particular to send the whole number of graduates that they knew, and other circulars especially stirring people up to send information favorable to the cure.

We suppose that ministers have no prejudice one way or the other unless employed by the company; that as a class, if they answer our appeal for information at all, they will tell the truth. And we be-

lieve that physicians, unless interested in some other system of treating such cases, will tell the truth. Further, we think ministers would be quite likely to come in contact sooner or later with a large number of permanent cures; for nothing is more talked about in a community than a genuine reformation from publicly known drunkenness. And we suppose that physicians would be most likely to come in contact with relapses, especially when followed by insanity, suicide and other conditions requiring care of treatment.

Some unsophisticated persons connected with Keeley institutions—before they heard the proclamation of hostility from headquarters—wrote us commanding in high degree the simplicity of the plan.

It must be remembered that there are alleged to be hundreds of thousands of persons who have taken these treatments in every State in the Union.

Now we have not examined the results of our inquiries. Immediately after publishing the proposition, large numbers of letters began to arrive. We instructed the office editor to file them carefully.

The investigation, so far as we are concerned, will be terminated on the last day of March. At that time the tabulation of the returns, which will be made by disinterested persons, will be submitted to the editor. The result will then be announced.—*Christian Advocate* (N. Y.), Jan. 31, 1895.

THE ANTISEPTIC TREATMENT OF SCARLET FEVER.

Dr. W. Jamison (*London Practitioner*) says that there appears to be four points requiring consideration: (1) The course of the infectious principle, (2) the treatment of the throat and mucous membranes, (3) the management of the skin, (4) the value of the "so-called" complete isolation alone, as compared with antiseptic measures and restricted isolation.

1. There are three routes by which scarlatinal poison can enter the system: (a) by direct inoculation, which is rare; (b) by being swallowed, a more common source, the medium frequently being milk, a fluid in which the virus grows rapidly; (c) by inhalation, the most common method of transmission. Probably in all cases the first symptoms are manifested in the throat; the second, usually within twenty-four hours, as the eruption on the skin. It is almost certain that during the period of pyrexia the virus is multiplying in the blood, and is in process of being conveyed to the under surface of the skin. Deposited beneath the epidermis, it rises through its layers and is finally cast off in flakes of exfoliating cuticle. Dr. J. has seen desquamation commence on the fourth day, but in the majority of instances it manifests itself from the ninth to the eleventh day. The process of "peeling" is not completed, if uninterfered with, until the end of the eighth week. It is

never absent in a genuine case of scarlet fever.

2. The best application to the throat is a spray of peroxide of hydrogen, ten-volume strength, repeated from three times daily to once in two hours. It should be continued, the intervals being extended, till its application no longer induces pain.

3. As regards the management of the skin, in the stage of exanthem we must favor the development of the rash by warm baths, which are best given at night, after which the entire surface must be smeared with eight ounces of almond or olive oil, containing a fluid dram of carbolic acid and two or four fluid drams of oil eucalyptus. When desquamation commences the warm baths must be supplemented by soap. Keep the patient in bed for three weeks, who should not be allowed to mix with others until peeling is completed and the hair washed several times.

4. Dr. J. is of the opinion that isolation alone cannot prevent infection, but no risk exists if the antiseptic precautions described are attended to. The nurse ought to wear a cotton wrapper, which can be laid aside when she leaves the room. The bed and body linen should be immersed in carbolic solution after being taken from the room.—*The Medical Progress*.

THE ADVANTAGE OF ATMOSPHERIC DISTENTION OF THE
RECTUM, WITH DISLODGEMENT OF THE SMALL
INTESTINES, IN THE BIMANUAL EX-
AMINATION OF UTERUS,
OVARIES AND TUBES.

Howard A. Kelly (*American Journal of Obstetrics*), suggests a procedure for overcoming the embarrassment experienced by the crowding of the small intestines down into the pelvis and the consequent liability of making a false diagnosis of pelvic disease. Coils of small intestines in the pelvis containing fluid often feel tense and fluctuating, and thus readily impose themselves upon the examiner as large cystic ovaries, or leave him in doubt as to their true nature. The complete removal of these impediments may be satisfactorily effected in the following manner: The patient is placed in the knee-breast posture, with shoulders on the table and hips high and thighs vertical. The anal orifice is opened by a small speculum or tube, allowing the air to rush into the rectum. The explanation of this phenomenon is that, upon assuming the knee-breast posture, the small intestines gravitate along the anterior abdominal wall into the upper abdomen towards the diaphragm, creating a suction at the most elevated portion, which is the pelvic extremity, by means of which the whole ampulla and rectum balloon out with air as soon as the anus is opened, and the distended rectum applies itself broadly over the posterior surface of

the uterus and left broad ligament. Before making such an examination, both rectum and bladder must be thoroughly emptied. Immediately after filling the rectum with air the tube is removed, the patient placed in the ordinary dorsal position with limbs flexed upon the abdomen, and the bimanual examination made per rectum and abdomen. The index finger introduced within the anus experience at once the sensation of entering a large cavity filled with air, in which the customary resistance is absent. The communication with the upper bowel between the utero-sacral folds is, under these circumstances, readily found, and the finger is conducted behind the broad ligament, when, on using the outside hand in assistance, uterus, broad ligaments, ovaries and tubes are at once palpated directly through the rectal wall, without resistance and with startling distinctness. The true pelvic viscera thus seen, as it were, to be skeletonized in the pelvis, lying so clearly exposed to touch that the minuter surface peculiarities, fissures and elevations, and changes in consistence, can be detected, and a diagnosis made more satisfactorily, more rapidly and with far less effort than under ordinary conditions.

TEA INTOXICATION.

To speak of this beverage as "The cups which cheer but not inebriate," must be regarded as an instance of purely poetic license.

As the best work of the poet is likely to be produced when he is thoroughly intoxicated with his subject, this line may be regarded as of such origin. Certainly it belongs to the realm of poetic fancy rather than to that of scientific fact. And it may be claimed that its author, by his subsequent melancholia and suicide, demonstrated the danger of indulgence in this direction.

No one who has practiced among the poor of a large city can have failed to recognize the baneful effects of excessive tea-drinking, especially among sewing women. James Wood (*Medical News*) says:

Of 1,000 consecutive cases applying for general treatment at our largest dispensary, 100, or 10 per cent. were found to be liberal indulgers in tea, and suffering from its deleterious effects, and no one of which came for treatment of the tea habit, but for various other complaints. They were loth, when apprised of the cause of their

illness, to believe that such a harmless household commodity ever produced any bad effects. Of these 100 cases, 20 per cent. complained of persistent dizziness, 19 per cent. of indigestion, 45 per cent. of headache, 20 per cent. of despondency, 19 per cent. of palpitation of the heart, and 15 per cent. of insomnia.

When tea has been used for a considerable period in excess and its detrimental action has been constant, we have well-defined symptoms supervene, a few of which are such as vertigo, mental confusion, sensible palpitation of the heart, restlessness, insomnia, hallucinations, "nightmare," nausea, neuralgia, anor-

exia, constipation, prostration and anxiety, and a peculiar kind of intoxication ending after hours of vigil in a torpor from exhaustion.

What worse line of symptoms could follow the use of a beverage so commonly employed, it is hard to imagine, and that many people use it to excess is unquestionable. Many have confessed to an inability to "get through the day" without copious imbibitions of what is, in many cases, a strong decoction. Some drink every twenty-four hours as much as fifteen pints, and some there are who are unable to judge of how much they consume.—*Philadelphia Polyclinic*.

THE PRESENT POSITION OF THE LICHEN QUESTION.

This was one of the subjects submitted to the Dermatological Section of the International Congress in Rome, and the opinions expressed thereon by two of the speakers have come under our notice. Mr. Malcolm Morris, after an exhaustive review of the several statements made by authors of eminence since Willan's time, showing the confusion which even now reigns as to what is and what is not to be regarded as lichen, thus formulates his own conclusions as a contribution to the settlement of the question. (1) Lichen is not a disease, but a type of lesion. (2) The term should be reserved for the clinical entity described by Erasmus Wilson under the name of lichen planus, which is the same as Hebra's lichen ruber. (3) The affection described by Kaposi under the name of lichen ruber acuminatus is identical with that described by Devergie and Besnier as pityriasis rubra pilaris. (4) Other forms of lichen—obtusus, hypertrophicus, verrucosus, etc.—are variants of the typical form, the Hebra-Wilson typical lichen planus. (5) The group of symptoms to which the name of lichen planus is applied is probably caused by a variety of factors, but at present we are almost entirely in the dark as to its pathogenesis. (*Med. Press and Circular*, June 27, 1894.) Neisser, again, while he agrees with much of what has been said by Malcolm Morris, holds that, (1) Lichen ruber appears in two principal forms, which

are to be distinguished as lichen ruber dianus (Wilson) and lichen ruber acuminatus. All other eruptive forms described under different names are modifications of this chief type. (2) Pityriasis ruber (Devergie-Besnier) is a disease *sui generis* and a keratinosis, that is, a disease with essential anomalies of keratinization of an acquired character. At the same time he does not strictly adhere to the description of lichen ruber acuminatus given by Hebra, senior, nor to that provided by Kaposi, since he thinks that the two authors last named referred to entirely distinct diseases, the sole common element being the acuminata form of the lesions. It would thus appear that for some time to come many various opinions will continue to be held as to the constitution of the lichen family.

Sterilization of Doctors.

It has been proposed by Gutmann that stations be erected in convenient localities in cities and large towns where physicians may go to be thoroughly disinfected immediately after they have visited a case of infectious disease, and before paying any further visits. The operation will take about fifteen minutes, and then the doctor may go about his business, proud in the consciousness of being clean and no longer a menace to the health of his fellows.

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M.D.

MEDICINE

Intubation in Germany.

The Children's Hospital at Leipzig is the only one in Germany where intubation is regularly employed. Baginski formerly used it, but now prefers tracheotomy in most cases. The results at Leipzig are very good, over 200 intubations having been made in the last two years with 82 per cent. recoveries. Carstens has modified the O'Dwyer tube a little and inserts it while the child is lying on its back in bed instead of sitting in the upright posture. The presence of a tube in the larynx usually renders the swallowing of liquids difficult, and thus the taking of the necessary amount of food is apt to be interfered with. This difficulty is met in America by the giving of solid foods, or by placing a patient upon the back with the head lower than the rest of the body while swallowing. In Leipzig, however, all intubated patients are fed through the catheter, so that there is no diminution in the amount of food given. The tube is worn from two to five days. If left longer than this, it is apt to cause ulceration. If at the end of five days relief of stenosis is called for, tracheotomy is performed. This has been necessary but twelve times in two years.—*Physician and Surgeon.*

The Heart in Typhoid Fever.

Dr. Huchard considers that the cardiac symptoms in typhoid fever may be due not only to myocarditis, but also to functional disturbances of the innervation of the heart. These symptoms disappear far too rapidly to be ascribed to myocarditis. Clinical experience has also shown that bradycardia, tachycardia and all other deviations from the normal rhythm of the heart depend upon a functional disturbance of the pneumogastric nerves. The action of the microbial toxins may also be purely functional.—*Med. Week.*

Pathogenesis and Treatment of Influenza.

It is well known how popular the quinine treatment of influenza was when that *maladie à la mode* visited our shores. So far as my knowledge goes this mode of treatment was strictly empirical, no laboratory experiments having been made on its action. The medical world will therefore be glad to know that the experiments of M. Mosse have confirmed the good opinion entertained of the value of this drug in combatting la grippe. Rabbits were inoculated with the blood of influenza patients, and then quinine was injected subcutaneously. 4 out of 6 of these animals remained unaffected, while test rabbits unprotected by the drug became very ill. Again,

rabbits inoculated with pure cultures of Pfeiffer's microbe (furnished by M. Roux) were quite capable of supporting this inoculation, provided subcutaneous injections of quinine had been previously practiced. Of 3 unprotected rabbits, 2 were killed by the inoculation. Efforts to cultivate (on gelatine) the pathogenic bacillus from the blood of an influenza patient were always unsuccessful. In one instance the pneumococcus and in another the staphylococcus were obtained. The blood of animals experimentally infected with influenza yielded the specific micro-organism only on one occasion. This culture was endowed with but feeble vitality and proved to be non virulent. M. Mosse arrives at the conclusion that the influenza bacillus is found only exceptionally in the blood, and that when so found its virulence is enfeebled. It is, moreover, unable to live in an organism in which the drug in question circulates, viz., quinine. It would thus appear that the exhibition of quinine as a prophylactic is justified; that it should be prescribed in large doses as an abortive agent; and that, finally, grave secondary infections, especially if due to the pneumococcus, call for hypodermic injections of quinine.—*Lancet; Med. Rec.*

Some Symptoms Which Simulate Disease of the Pelvic Organs in Women—Their Causes and Treatment.

Dr. A. Rabagliati: The condition often described as ovarian neuralgia is, as a rule, neither ovarian nor neuralgic, though both may coexist; but is essentially a rheumatic perimyitis, due to improper nutrition and the absence of proper exercises in the open air, and can be cured without operation. In the kind of cases under consideration it is assumed that there is no gross disease of the pelvic organs beyond, perhaps, a slight displacement of the uterus or its appendages. In such cases oophorectomy is, in my opinion, an unjustifiable operation, and a much better procedure is my own operation of cutting down on the umbilicus, rawing the surfaces and bringing them together, though, as a rule, not even this is necessary. In the examination of these women we find tenderness of the oblique muscles of the abdomen, of the recti muscles, of the umbilicus itself, of the quadratus lumborum muscles, of the sacroiliac synchondrosis, and also of the sacral origin of the glutei maximi. This tenderness, I think, explains the complaint usually made by these women of being constantly tired. The kind of pain is an aching one, such as is associated with trouble in muscles, rather than numbness, tingling or smarting, such as characterize nervous involvement. Other muscles may also be affected, such as the solei and gastrocnemel, the quadriceps ex-

tensors, etc. Minor degrees of disease of the uterine appendages may of course coincide with this condition, but the latter is really the main cause of the patient's suffering. There are many reasons for believing that this muscle trouble is rheumatic in character, and these have led me to designate the affection as perimysitis rheumatica. The principal cause is, I believe, the improper feeding of these women, especially the bread and tea which they take in such large quantities, and the best treatment is to place them on a liberal diet, combating the rheumatism by appropriate remedies and washing out the waste with hot water taken an hour after food three times a day. I wish to lay great stress also on the value of bathing followed by methodical exercises calculated to put into action the disused muscles.—*Arch. Gynec.*

Dangers of Naphthol.

Baatz, in the British *Medical Journal*, has seen acute nephritis follow friction with an ointment containing 2 per cent. of naphthol beta in two brothers aged six and eight, respectively. The remedy was applied for scabies. This was cured, but three weeks afterwards albuminuria with edema of the lower limbs came on. One of the boys died, and the diagnosis of nephritis was verified by post mortem examination. In neither case had minuria previously existed, nor was there any history of an affection which could have been the starting point of nephritis. The author therefore warns against the use of naphthol beta as a remedy for scabies in spite of the powerful curative effects.

Spontaneous Cure in Amebic Dysentery.

The rarity of spontaneous cure in such severe forms of dysentery has led Drs. George J. Preston and John Ruhrah to report a case in the New York *Medical Journal*. A colored man aged twenty-two, with a fairly good history, was admitted on account of dysentery. Examination of the stools showed the typical amebæ. Patient was given large doses of the tincture of iron. The dysentery was not treated, but in the next few days the amebæ disappeared and the man recovered.

Puerperal Neuritis.

With an expansion of our knowledge of the complications of the parturient and puerperal states, and with a glowing familiarity with the lesions of the peripheral nerves, we have come to learn that the intoxications dependent upon infection through wounds and lacerations resulting in the course of child-birth may give rise to a multiple neuritis comparable to that of rheumatic, plumbic, alcoholic, or other like origin. A typical case of this kind was recently reported by Lountz (*Nouvelles Archives d'Obstétrique et de Gynécologie*), at a meeting of the Société de Neurologie, of Moscow. The patient was a primipara, twenty-four years old, who passed through pregnancy and labor without complication, the child dying, however, on the

fifteenth day. Three weeks after the labor the woman presented swelling of the face, edema of the extremities, difficulty of deglutition, diplopia, pains in the extremities, and then numbness and weakness of the upper and lower members. Common sensibility was little affected, but the muscular sense was impaired. The knee-jerks and the elbow-jerks were abolished, and electric irritability was diminished. These symptoms were progressive for two weeks. To them were added arrhythmia of the heart, acceleration of the pulse, and attacks of suffocation. The lower extremities became entirely paralyzed. By and by, however, the symptoms gradually ameliorated, except the paraplegia which persisted for a long time. It is assumed that this depended upon a polyneuritis due to infection through a laceration of the perineum incurred during labor.—*Medical News*.

Physiological Rest in the Treatment of Prolapse of the Rectum

Bryant, (*Mathew's Medical Quarterly*), reports the case of a man operated on seven times for the relief of extensive prolapse of the anus, with its attendant distressing symptoms. Until the last operation, surgical intervention had been of little benefit. Bryant, to whom he finally came, made an artificial anus in the left groin, putting the patient to bed for two weeks, meaning to proceed to further treatment. But this operation was followed by so much relief and by such a marked diminution in the pressure that he was content to adopt no further procedure. He submits the following proposition as a conclusion to his paper:

That the proper performance of the physiological functions of the rectum contributes greatly to the advancement of rectal disease and to the afflicted.

That the complete vicarious discharge of the feces through an artificial anus located in the sigmoid flexure reduces the physiological demands on each structure of the rectum to a minimum.

That the lessening of the physiological requirements is commonly in direct proportion to the diminution of the fecal flow through the rectum.

That the cessation or lessening of the fecal discharge per rectum exercises a palliative and curative influence on diseases of the rectum.

That in certain cases of obstinate rectal prolapse the formation of a vicarious channel for fecal discharge is justifiable, both as a palliative and curative measure.

That the preliminary establishment of such a channel for the purposes of cleanliness and the prevention of infection is justifiable in many grave operations for prolapse of the rectum.

That the dangers attendant on the formation of an inguinal anus are much less than those invited by the contact of fecal discharges with large operative surfaces of the rectum.

That the case just presented has been, without special risk, greatly benefited, and

may be finally cured, through the agency of an artificial anus.

That when cure takes place, great care must be exercised thereafter, otherwise the prolapse will return.

Bichromate of Potassium as a Remedy in Gastric Affections.

We offer the following synopsis of a paper on the above subject, which was read at the International Medical Congress by Professor T. R. Frazier: Notwithstanding the assertion made in 1883, by so high authority as Vulpian, of the value of bichromate of potassium in the treatment of several forms of gastric disturbance, this substance has not yet gained a position among the many substances that are used in the treatment of these affections. Having, in 1884, treated with gratifying success a case of persistent gastric disorder by the administration of small doses of bichromate of potassium, I have since that time administered it in a large number of cases, and the results have been so favorable that I feel myself justified in now stating my opinion of the therapeutic value of the substance. The cases have been recorded in two groups, the first group comprehending 18 cases of various forms of dyspepsia unassociated with evidence of gastric ulcer, and the second group, 10 cases in which distinctive symptoms of ulcer had been present at some previous time. The doses administered in the above cases have varied $\frac{1}{2}$ grain to 1-6 grain, twice daily, and in most instances the smaller dose was found to be sufficient. The dose should be given during fasting and on an empty stomach as possible. The administration was effected in the form of pills or an aqueous solution which may be flavored with tolu or orange. An examination of these cases shows that bichromate of potassium is capable of relieving, and often in a short time of removing, the entire group of symptoms—if we except constipation and anemia—encountered in dyspepsia, and especially pain, nausea, vomiting and gastric tenderness. In a few cases of acute gastrice ulceration, with hematemesis, in which I have given bichromate of potassium, the results were not favorable, as it did not succeed in checking the bleeding. Bichromate of potassium possesses a strong anti-putrefactive power, which is exhibited in albuminous, saccharine and phosphatic urines, even with a 0.01 solution. This action probably constitutes one of the causes of its anti-dyspeptic therapeutic value, but there are undoubtedly other causes, such as direct or indirect analgesic action, and probably a selective action on the nutrition of function certain histological structures, which I am now engaged in endeavoring to determine.—*Lancet.*

Causes of Sexual Debility.

Dr. F. R. Sturgis gives the following summary of his views at the termination of a very instructive paper: 1. That the cases of sexual debility which are marked by imper-

fect erections and by premature emissions are usually, if not entirely, due to hyperesthesia of some portion of the urethra. 2. That masturbation has very little, if anything, to do with it beyond the fact that if indulged in to excess it may induce a tendency toward this hyperesthetic condition, but this is no more marked in masturbators than it is in those persons who indulge to excess in the venereal act. 3. That organic stricture has little, if anything, to do with it; but that associated with this hyperesthetic condition there is an irritable condition of the canal which produces spasmotic contractions of the urethra upon attempts to pass instruments, oftentimes during the first act of micturition and at the time of connection. 4. That varicocele plays no unimportant part in these cases. 5. That neuralgia of the testis, if a cause of this disease, induced it merely as a secondary consequence to the pain, which is one of the distinguishing features of this disease. 6. That tuberculosis, syphilis and gonorrhœa may also play their part, and should all be reckoned with in summing up the causes which may induce this peculiar and depressing condition of affairs.—*Gillard's Med. Jour.*

Chronic Recurrent Tetanus Treated with Thyroid Extract.

At a recent meeting of Berlin Medical Society, Gottstein reported a case from the clinic of Mikulicz, in which a thirty-four-year-old man who had suffered from attacks of tetanus since his twelfth year, was found to have no signs of a thyroid gland; and as tetanus is one of the symptoms observed in animals deprived of their thyroids, he was treated by having a goitre from another patient implanted in the abdomen. The result was very gratifying as the frequency of the attacks was very much reduced. This improvement was only temporary, whereupon a second similar implantation was made, with the same result, decided improvement with subsequent relapse into the original condition. The man was then put upon thyroid extract by the mouth, whereupon the attacks diminished gradually from twenty a day to three or four a day, at which number they have remained. The general condition has been much improved.—*Deutsche Med. Wochenschrift.*

Turpentine in Incontinence of Urine.

The unpleasant smell emitted by persons suffering from incontinence of urine can be conveniently covered, according to Dr. Emminghaus by means of ten-drop doses of turpentine administered in milk or water three times a day. This converts the smell of stale urine into an odor resembling that of violets, as is well known to persons who have taken turpentine. The remedy is perfectly harmless in most cases, and has been given by Professor Emminghaus for many weeks at a time without any inconvenience. It is, however, contraindicated in ulcer of the stomach, gastric catarrh, and nephritis, and also in

some persons in whom turpentine tends to upset the digestive functions.—*London Lancet.*

Lactophenin.

If the results of Jaxuet and of Strauss (*Abst. in Fortschritte d. Medicine*), should be confirmed, lactophenin will certainly fill a long-felt want for an effective antipyretic which does not at times cause alarming symptoms. The compound is a near relative of phenacetin, differing from it only on having the acetic acid which is combined with the ammonia of the latter, replaced by lactic acid. It is said to be a prompt and effective antipyretic with the addition of a decided hypnotic effect. Its great advantage, however, is in the freedom from disturbing secondary effects. Even where the fall of temperature produced by it has been very great (9° F.), the patient feels perfectly comfortable with a quiet, full pulse and a clear intellect. As an anti-neuralic and sedative it ranks with antipyrine, phenacetin, etc.

To Relieve the Thirst of Diabetics.

Pilocarpin may be administered in solution or in pill form. The pills are best prepared by the addition of glycerin and gum arabic. Each contains gr. $\frac{1}{10}$ of pilocarpin nitrate. For the solution the following form is given:

Pilocarpin nitrat.....	gr. $\frac{3}{4}$
Spirit vini dilut.....	mxv
Aqua.....	8j

M. Sig.: The tongue is to be moistened with 5 or 6 drops of this solution four or five times daily.

—*Nouv. Remedes.*

Vomiting in Pregnancy.

Lutaud (*Rev. Obstet. et Gyn.*) states that vomiting of pregnancy is best treated by cocaine. The action of this drug is often strengthened by combining it with antipyrin. Thus follows the prescription:

Chlorhyd. cocaine.....	grs. jss
Antipyrin.....	grs. xvi
Aq. dest.....	8 iv

Sig.: Teaspoonful every half-hour until the vomiting ceases.

If the stomach will not tolerate the quantity of liquid, ten drops of a one and a-half or two per cent. solution of cocaine are administered, repeated at one or two-hour intervals.

At times the application of cocaine to the os is extremely valuable. The following prescription may be used:

Hydrochlor. cocaine	grs. xvi
Ext. bellad.	grs. iv
Vaseline.....	8 ss

Cotin's method of dilating the os with the finger sometimes causes immediate cessation of vomiting. Occasional success will follow Routh's procedure, which consists in exposing the uterine neck by means of a speculum and painting with tincture of iodide. In cases of moderate severity the following mixture will be found serviceable:

Tinct. Iodine.....	1/2 3 ij
Chloroform.....	

Sig.: Five drops night and morning at meal times, taken in Seltzer-water.

—*Kan. Med. Record.*

Hydrochlorate of Chalk for Pruritus Ani.

Take (*Sem. Med.*), a piece of cotton gauze two or three centimeters long, which has been moistened with a solution of hydrochlorate of chalk, two to the hundred. Push up the anus and leave in place until sharp smarting commences. Then remove it and wipe surface of anus dry. Itching immediately ceases. If it should return employ the same proceeding. It appears that this solution simultaneously clears up all the eczematous patches about the anus and scrotum, a condition so generally concomitant with an anal itch.

Chrysarobin in Chronic Ringworm of the Scalp.

Duhring (*American Journal of the Medical Sciences*), as the result of an extended experience with a large number of chronic cases of ringworm of the scalp in a boys' school, arrives at the conclusion that chrysarobin was the most active and potent parasiticide employed. It was used in various strengths, but generally in the form of an ointment of one dram to the ounce. While, as a rule, it was well tolerated, the writer advises care in its employment, especially in avoiding the face.—*Int. Med. Magazine.*

A New Method of Making Palatable and Digestible Milk.

Dr. Robert T. Edes, of Boston, gives a valuable way of preparing milk where other methods have not proved useful:

A pint of milk is gently warmed. Into it is dropped, very slowly and with constant stirring, about twenty minims of the dilute hydrochloric acid of the United States Pharmacopælia. The milk should be stirred until it cools. In this way a very fine flocculent coagulum is produced, floating in the whey, which is easily accessible to the digestive secretions, while the whole fluid has lost somewhat of the flat and cloying taste which makes it unacceptable to so many. It will be noticed that milk prepared in this way differs from the various "wheys" in the highly important particular that the casein is retained and used, instead of being separated out as a distinct product, while it avoids the bitterness of pancreatinized milk.—*Boston Med. and Surg. Jour.*

Potassium Nitrate in the Treatment of Phlegmasia Alba Dolens.

Hovnanian, (*Medical News*) describes his use of nitrate of potassium in this affection:

It has fallen to his lot to treat three well-marked cases of phlegmasia alba dolens with potassium nitrate with such gratifying results as to seem to justify publication.

Mrs. H., twenty-three years old, was delivered of her first child by her family physician with instruments, and sustained extensive lacerations of the cervix uteri and perineum, which at the time were not repaired, but were left for a secondary operation. Twelve days after delivery she complained of pain and heaviness in the left leg, and within three days there developed well-marked phlegmasia. On the fourth day of this complication the writer saw the patient in great agony, with a temperature of 105.2° F., a pulse of 130, and respirations 25. The limb was so turgid and swollen that there seemed to be great danger of gangrene or rupture. The woman was at once given morphine sulphate ($\frac{1}{3}$ grain) hypodermically, and her limb was wrapped with cotton and placed on a feather pillow at a very obtuse angle. Hovnanian then prescribed a solution of potassium nitrate in water, representing 5-grain doses, to be given every hour until his return. Seven hours later he found his patient in better condition, with a temperature of 103° F., a pulse of 112, and respirations 22, and with less pain and discomfort. The swelling seemed to be less tense and the veins less engorged. The nitrate was continued as before until morning, when he found her in yet better condition. She had slept well during the night, although she had been wakened regularly for her medicine. Her temperature was 100° F., her pulse 95, her respirations 20. The swelling was reduced to less than half, and the returning circulation was fairly well established. There was no pain whatever and but slight tenderness on pressure. The medicine continued every two hours during the day, until the author saw her late in the evening, with a temperature of 99° F., a pulse of 90, and respirations 18. The swelling had almost entirely gone and everything was in good condition. The nitrate was continued for two days in smaller doses and at longer intervals, and then discontinued.

Two other equally typical cases are also recorded in this paper.

Nephritis Following Friction with Naphthol.

In the *Revue internationale de médecine et de chirurgie pratiques* there is an abstract of an article on this subject by M. Baatz which appeared in the *Centralblatt für innere Medicin*. The author relates two cases of nephritis following naphthol frictions for the itch. In the first case, that of a boy nine years old, the nephritis, which was not very pronounced, manifested itself in edema of the legs, the feet, and the scrotum, accompanied with slight albuminuria. Recovery followed very quickly under the influence of a proper diet and baths. In the second case, that of a boy six years old, anasarca and symptoms of broncho-pneumonia were observed when he entered the hospital. The urine, which was brownish in color, contained albumen, hyaline casts, and red blood corpuscles. Notwithstanding the treatment, which was care-

fully applied as soon as the symptoms appeared, the situation became aggravated and the child died four days after his entrance into the hospital. At the autopsy extensive broncho pneumonia of the left base and parenchymatous nephritis were found. The author thinks that in both cases nephritis had been provoked by the naphthol frictions. He recalls the fact that similar cases have been observed before by other authors. Ka- pos has published an account of a boy who, after friction with naphthol for prurigo, was taken with ischuria, with bloody urine, vomiting, loss of consciousness, and eclampsia which persisted for several days. The child recovered. Lewier has related the case of a man who, after fifteen days of naphthol frictions, was taken with acute nephritis with albuminuria. Finally Frohmuller has observed three cases of naphthol poisoning where the principal symptoms were acute nephritis and attacks of mania.

The Dietetic Treatment of Phthisis.

The following suggestions by Dr. Henry P. Loomis (*The Practitioner*) are worthy of careful consideration:

1. Never take cough mixtures if they can possibly be avoided.
2. Food should be taken at least six times in the twenty-four hour; light repasts between the meals and on retiring.
3. Never eat when suffering from bodily or mental fatigue or nervous excitement.
4. Take a nap or at least lie down for twenty minutes before the midday and evening meal.
5. Take only a small amount of fluid with the meals.
6. The starches and sugars should be avoided; also indigestible articles of diet.
7. As far as possible each meal should consist of articles requiring about the same time to digest.
8. Only eat so much as can be easily digested in the time allowed.
9. As long as possible systematic exercise should be taken to favor assimilation and exertion; when this is impossible, massage or passive exercise should be undergone.
10. The food must be nicely prepared and daintily served—made inviting in every way.

Chronic Constipation and Its Treatment.

The causes of constipation (James D. Staple in *Med. Times and Hosp. Gaz.*) are:

1. Lack of tone in the muscular coat of the intestines causing a decrease in peristalsis, usually due to imperfect regional innervation.

2. Deficient secretion or excessive absorption.

People leading sedentary lives are predisposed to constipation.

The symptoms (excepting in those cases due to organic disease) are:

Loss of appetite; imperfect digestion, nausea, headache, irritability, mental depression, bad complexion, acne, sleeplessness. Hysteria in the female and hypocondria in

the male have been often caused by constipation, and it is even stated that a condition of disease bordering upon insanity may be brought about by a long-continued defective formation of feces and imperfect action of the bowels.

Moreover, the material which should have been removed will accumulate in the blood, and in consequence such diseases as gout, rheumatism, etc., may be developed.

The treatment may be divided into (1) non-medicinal and (2) medicinal. Under the non-medicinal we may include: (a) correction of diet; (b) fluids before breakfast; (c) exercise; (d) cold bath or rubbing the body with a rough towel; (e) kneading the abdomen; (f) going to stool at a regular set time.

In the medicinal treatment of chronic constipation avoid giving purgatives, the reason being that patients acquire the habit of depending on them. Small glycerin suppositories are highly recommended, being rapid and certain in action and their use unattended with griping or irritation of the gastro-intestinal tract. In cases where aperients must be given cascara sagrada is recommended, but even in these cases it is well to begin with some natural mineral water.

Eucalyptol in Eruptive Diseases.

The following, says an exchange, will increase the activity of the skin and besides prove an excellent antiseptic:

Eucalyptol.....	3 as
Carbolic acid	grs. v
Lanoline.....	3 ij

M. Apply over eruptive surface.

The Significance and Etiology of the Premature Discharge of Meconium.

E. Rossa (*Archiv. f. Gynak.*) states that it is commonly believed that the escape of meconium before term is a sure sign that the fetus is in danger of asphyxia, and is therefore an indication for the hastening of delivery. The author's personal investigations have led him to doubt the correctness of this teaching. In a large number of cases the escape of meconium has no significance of the kind generally attached to it. The cause of the phenomenon is simply increased intestinal peristalsis, which may indeed be due to asphyxia, but may also be due to other less well defined causes. Among these the principal are diseases of the mother, and particularly gastro-intestinal disorders.

Chronic Rhinitis and Pharyngitis.

Dr. H. M. Dunlop, sanitarian at Battle Creek, Mich., claims (says *Prescription*) to have obtained excellent results from the application of the following:

Ol. cinnamon.....	gits. xx
Eucalyptol.....	3 iij
Ol. gaultheriae.....	gits. xx
Menthol crystal.....	grs. xx

Liq. albolene..... 3 iij

M. Use with atomizer.

Virchow's View of the New Treatment of Diphtheria.

Virchow's opinion of the efficacy of the new treatment by blood serum of diphtheria may be thus summarized: The serum exercises a strong protective effect for weeks, perhaps even for three to four months; but it remains to be seen whether this effect is permanent, and whether—and this is the cardinal question—it is really possible to cure diphtheria by this remedy. Much however, is gained if we succeed in protecting even one child in a family in which three or four are ill of this malady. And that we may accomplish this appears extremely probable.—*German Correspondent, Med. Press.*

Chloral in the Treatment of Boils.

(*Le Chloral contre les Furoncles. Bull. Gen. de Therapeutique.*) By M. Spehn.

The author recommends very highly as far superior to all other treatment the use of chloral externally in this troublesome class of affections. He directs that the boil be kept covered with a tampon of cotton-wool soaked in the following solution:

Chloral. hydrat.....	3 iiss
Aqua.....	5 aij
Glycerin.....	1 3 v.—M.

—*Int. Med. Magazine.*

SURGERY.

Circumcision.

In most cases the foreskin adjusts itself to conditions of perfect cleanliness at the time of puberty, if not before. Physicians are not so senseless as to unnecessary mutilate themselves and their families. Circumcision is a relic of barbarous and semicivilized times, before soap and water and sanitation had been preached. It no doubt served a useful purpose among the nomadic tribes of tropical countries. But in these days physicians should cease to preach or impose upon their patients an unnecessary and irrational mutilation.

The rite which in these modern times might be substituted for the early religious ceremony of circumcision would, according to some, be resection of the spermatic cord of the vicious and defective classes, so that they should cease to propagate their kind. Spermatectomy will probably triumph over and replace circumcision if anything does.—*Editorial in Med. Rec., N. Y.*

Chordee.

In a paper on "Local Anesthesia," Dr. Wm. P. Carr, of Washington, D. C., writes, *Med. Bulletin*: "In this connection I may mention a fact well worth knowing, and I think not generally known, the chordee may be entirely and promptly relieved by putting on a condom containing two or three drachms of a two per cent. solution of carbolic acid, and that any pain in the penile portion of the urethra or pendulous penis may be controlled in this way."

Strangulation of the Tonsils.

Dr. Marcel, who is chief of the clinic for diseases of the nose and throat at Bucharest, describes the removal of the tonsils with the cold snare, which he has performed in fifty cases. He always makes use of a snare with three rings and without a screw, employing the same kind of wire as that used for removal of nasal polypi. In the after treatment he recommends gargles of carbolized water, with addition of oil of peppermint. On the following day in place of the tonsil is found a whitish exudation, and the patient experiences slight difficulty in swallowing which may last from a few hours to two or three days. The wound is completely healed in the course of eight days.

On the ground of the fifty cases treated the author formulates the following conclusions:

1. Strangulation of the tonsils by means of the cold snare is an easy procedure and attended by but little pain, even without the use of cocaine.

2. Although not the only method for removal of the tonsils, it is especially indicated for nervous children, and in cases of greatly enlarged tonsils.

3. This method is contra-indicated where the tonsils are incarcerated or extended too far beyond the faucial pillars.

4. The hemorrhage is often much slighter if the operation is performed slowly; at any rate, it is not more profuse than under the use of the tonsillotome or knife. It usually ceases within a few minutes; and should this fail to occur, it can be arrested by application of a small cotton tampon medicated with equal parts of iodoform and tannic acid.

5. The cold snare has the following advantages over the tonsillotome: (a) It is less likely to provoke fright in children. (b) It is a less costly instrument. (c) It can be more readily cleansed, and hence is more aseptic, especially if a new wire is used for every operation. (d) The removal of the tonsils is more thoroughly effected, although much less rapidly than with the tonsillotome.

6. The cold snare is to be preferred to the knife, because it requires the use of only one hand and does not produce injury of surrounding parts.—*Wien. Medic. Press.*

Fractures of the External Condyle.

Dr. F. E. Bunts summarizes his views as follows: Fractures of the external condyle are confined almost exclusively to children, and are usually the result of direct injury. Displacement of the fragment may take place in any direction except inward, and is sometimes accompanied by a dislocation of the radius and ulna. While good motions may generally be anticipated, ankylosis, either partial or complete is of frequent occurrence. An unusual prominence of the upper end of the fragment, widening of the joint, increase or decrease of the carrying angle of the forearm, may result under any treatment. No dogmatic line of treatment should be insisted upon. Early passive motion should be resorted to. The prudent surgeon will at once inform his patient or patient's parents of the

nature and probable consequences of the case, and refuse to promise them under any consideration that a perfect result will occur.—*Med. Age.*

Congenital Ptosis.

Dr. Mary Putnam Jacobi presented a baby with congenital ptosis. At birth, the eye had been completely closed, but subsequently the ptosis had become partial. It differed from cases of this kind previously reported in being unilateral. The condition is quite rare, and in most instances the recti muscles are involved, which is not true of the present case. In a case described by Schenckel all the ocular muscles were imperfectly developed, but accommodation was perfect, as was also the response of the pupils to light. In another report, mention is made of two members of the same family being affected in this way. Gower speaks of combined paralysis of the facial and abducens as being rather more common than paralysis of the oculo-motor nerve. The question of the syphilitic origin of this condition naturally suggests itself, but there seems to be no reason for suspecting such a constitutional taint in the case just presented. It is possible that it may be one of the parasyphilitic lesions. The speaker said that so far as she knew, the only attempt to remedy this condition had been made by Evans, of Louisville, who had operated upon a case of bilateral ptosis according to a method devised by Pannus. In brief, this consisted in taking a flap from the lower part of the eyelid, and uniting it to the occipito-frontalis muscle, the object of the operation being to make this muscle take the place of the missing levator. The result in the case reported has been fairly satisfactory.—*Archives of Pediatrics.*

Local Therapeutics of Phenacetine.

Although phenacetine has been chiefly utilized for internal administration as an antipyretic, antineuralegic and sedative, evidences are at hand showing its great value as a topical remedy in various diseases. In an article read some time ago before the Tennessee State Medical Society, Dr. M. H. Lee reported a number of cases of ulcers in which remarkable results were produced by the application of finely powdered phenacetine. The ulcers were of traumatic and specific character, and had resisted external and internal treatment. Under the application of phenacetine, however, immediate improvement was effected, pains, if present, being at once relieved and granulations appearing rapidly. Dr. D. Coit Taylor, of Providence, R. I., (*Med. World*) has obtained excellent results from the local employment of phenacetine in the treatment of rheumatic pains of joints, pains from sprains, contusions or bruises, and recommends the following formulae:

Phenacetine..... gr. 15-20

Spts. vini rectific.—Aqua bul. aa 1 ounce

Sig.: To be applied on cloths as hot as can be borne.

Phenacetin..... gr. 15-20
Lanoline..... 1 dram

M. Apply by manipulation.

According to the *Journal de Medecine de Paris (Therapeutic Gazette)* useful results are obtained in cases of acute rheumatism by applying phenacetin externally to the painful parts. The following prescription may be used:

Phenacetin..... gr. 75
Lanoline..... 6 drams
Olive oil..... a sufficient quantity

To be rubbed about the inflamed parts.

Phenacetin..... gr. 75
Alcohol..... 2 pints

In this solution dip compresses and apply to the painful parts.

Internal Hemorrhoids.

Dundore, after an exhaustive paper on the subject of internal hemorrhoids, concludes as follows:

1. The ligature is the safest method of operating for internal hemorrhoids, as there is less likelihood of its being followed by hemorrhage, stricture, or ulcers.

2. The clamp and cautery cause less pain, shorter convalescence, and are less likely to be followed by retention of urine than when the ligature is used; but hemorrhage and stricture of the rectum may very often follow their improper application.

3. The practice of Whitehead's method should be limited to those cases in which the entire circumference of the anus is involved. In ordinary cases of one or more hemorrhoids it should never be used, as it is liable to be followed by severe after-effects, and at best could produce no more radical result than the clamp and cautery or ligature.

4. Simple dilatation of the sphincter, injection of carbolic acid, and Manley's method are simple palliatives, and their use is very limited.

5. There is no single operation which is universal in all cases. Experience alone should suggest the most efficient method of treating each individual case. — *Mathews' Medical Quarterly.*

Fractures of the Humerus at the Elbow Joint.

Dr. C. W. Dulles calls attention to the point in the management of the fractures of the humerus at the elbow joint that if the forearm be semi-pronated and fully flexed upon the humerus, the head of the radius and the coronoid and olecranon processes of the ulna will hold the inner and outer portions of the lower end of the humerus in a correct anatomical relation to each other and to the bones of the forearm. To meet these indications he applies from the fingers to the shoulder, smoothly and with moderate tension, a soft flannel bandage, avoiding undue pressure upon the anterior angle at the elbow by having the forearm flexed and semi-pronated while the bandage is applied. After this the bend at the elbow is filled with some cotton, a splint is laid against the arm with very moderate cotton padding—not bound on with a bandage, but just laid loosely on—and the whole is enclosed with a good roller bandage. Any splint may be used which will maintain the forearm in full flexion upon the upper arm. For this purpose a splint with a very acute angle, to fit either side of the arm, or an anterior angular splint will answer—*Boston Med. and Surg. Jour.*

Treatment of Ulcers of the Leg.

Frank (*Jour. of Amer. Med. Asso.*) treats these cases as follows: The granulations are thoroughly cleansed at first. Then they are treated with silver nitrate if the granulations are hypertrophic, or with iodiform if the surface is putrid, torpid and lacking in vitality. The leg is then washed and shaved, and a moderately thick layer of warm gelatine is applied to the ulcer with a brush. The gelatine is thus prepared:

Oxide of zinc.....	30 parts
White gelatine.....	40 "
Glycerine.....	50 "
Water.....	90 "

A small patch of gauze is added as a covering and a gauze bandage from the toe upward. If you want firm dressing, cover the bandage with another layer of gelatine, and continue the bandage from above downward; let the gelatine cool and dry. If the discharge is abundant repeat the dressing every fourth day. If it is less, keep it on for eight days.

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